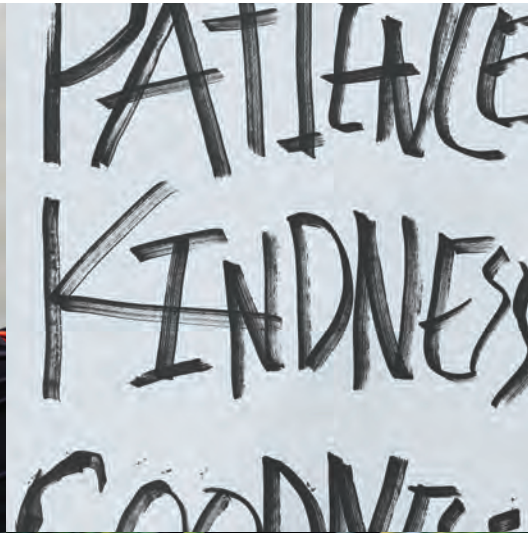




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3ts | turn the tide of suicide



Accessing Help for Self-Harm and Suicidal  
Behaviour in the Emergency Department:

**The Experiences of Service Users**



## Acknowledgements

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“I’d just say, the best advice I could possibly give is actually listen to the person that’s sitting in front of you. They’re not just a number, they’re not just there for the sake of being there. They’re asking for help, we’re crying out for help...”



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## Glossary and Acronyms

**Emergency Department (ED):** An Emergency Department is a department in a general hospital where people present with serious illness or injury. There are 26 adult Emergency Departments in public hospitals throughout the Republic of Ireland which are open 24 hours a day, 365 days a year.

**Self-harm:** Self-harm is a broad term to describe an intentional act of harming oneself which can include both self-harm with suicide intent (e.g. suicide attempt) but also self-harm where there is little/no intent to die. Both these forms of self-harm can serve different functions for different people.

**Suicidal ideation:** Having thoughts about suicide, considering or planning suicide.

**National Clinical Programme (NCP):** The NCP is the National Clinical Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self-Harm. The aim of the programme is to 'develop a standardised and effective process for the assessment and management of individuals of all age ranges including children, adolescents, adults and older adults who present with self-harm to the ED.' The NCP is currently running in 24 of the 26 adult EDs in the Republic of Ireland.

**Clinical Nurse Specialist (CNS):** A Clinical Nurse Specialist is a nurse working at an advanced level of practice in a specified area with specially focused knowledge and skills. They have undertaken post-registration education in their specialist role and work at a more autonomous level than a staff nurse. Clinical Nurse Specialists in Self-Harm are attached to the NCP in Ireland. In this report, many participants referred to them as the 'self-harm nurse'.

**Psychiatric Non Consultant Hospital Doctor (NCHD):** Within this report, the Psychiatric NCHD refers to doctors who are working in mental health and are on-call to the ED and may be called to undertake an assessment when a patient presents with self-harm or suicidal ideation when the CNS is unavailable.

**Suicide Crisis Assessment Nurse (SCAN):** A Suicide Crisis Assessment Nurse is a nurse who provides support to GPs in the assessment of patients presenting with self-harm or suicidal ideation in the primary care setting.

**Emergency Department Doctor:** Within this report, the 'ED doctor' refers to non-mental health doctors who are working in the ED and may be involved in the treatment of the patient's physical self-harm injuries.

**Triage:** Triage refers to a system of assessment operationalised in every ED where a triage nurse undertakes a preliminary assessment of all patients who present to determine the urgency of care required.

**River/marine patrols:** River/marine patrols are a volunteer service in place in some areas of Ireland where trained volunteers positioned along rivers/waterways look out for those in distress and who may be contemplating suicide. They aim to get the person to safety and call appropriate services (e.g. ambulance) to facilitate access to emergency support.

## Key Findings at a glance

The Emergency Department (ED) is often the first port of call for those who have self-harmed or experience suicidal behaviour. Indeed, for many people the ED is the only healthcare setting they come into contact with as a relatively large number of people are not referred on for specialised mental health services, while a minority will leave the ED before being formally assessed. Consequently, understanding how service users experience the ED when presenting with self-harm or suicidal behaviour is important to better respond to this cohort. This study explored service users' experiences of presenting to the ED with self-harm or suicidal behaviour.

This was a descriptive qualitative study in which in-depth interviews were undertaken with 50 participants who had presented to the ED for self-harm or suicidal behaviour in the Republic of Ireland within the preceding 5 years. The sample comprised 39 women and 11 men with a mean age of 34 years. Key findings from this study are presented in bullet form under the appropriate chapter heading.

### Presentation to the Emergency Department

- Participants reported presenting to 21 of the 26 adult Emergency Departments throughout the Republic of Ireland.
- 29 participants reported presenting to the ED more than once, and 35 participants are currently, or were in the past, attending a mental health service.
- Just under half (n=22) reported presenting with suicidal ideation without self-harm, with the remainder presenting following self-harm which comprised overdose and/or self-cutting.
- The primary pathway to the ED was self-presentation following a GP referral (n=22), followed by self-referral (including with family/friend) (n=14) and via ambulance (n=11). A small number (n=3) were referred to the ED by someone from within their mental health team.
- Approximately two-thirds (n=32) of participants were accompanied to the ED with someone (e.g. family member or friend), while the remainder presented on their own.
- All participants reported being seen by a triage nurse and many were seen by an ED doctor. Many were also seen by someone from the mental health team, most commonly the 'self-harm nurse'; however there was a large degree of uncertainty among many participants about who exactly they saw from the mental health team.
- Following their last presentation to the ED, 39 participants were discharged, 8 were admitted to a mental health unit and 3 were admitted to a medical ward.
- Half of the participants (n=25) reported having an overall negative experience of the ED, 7 had a positive experience while 18 had a mix of positive and negative experiences.



## Interventions and Care in the Emergency Department

### Assessment and Treatment

- Experiences of assessment were generally negative. It was viewed as being formulaic, a 'tick-box' exercise, rushed and mechanical.
- Participants reported that many non-mental health staff in the ED did not seem comfortable carrying out assessments and asking sensitive questions about mental health and suicide/self-harm in particular.
- There was an understanding that certain sensitive questions needed to be asked, but there was great variation in how these questions were asked.
- For those who had self-harmed there was an overarching focus on the physical injuries with little consideration of the mental distress that contributed to them.
- For those who had suicidal ideation with no self-harm, many perceived that there was little to be done for them and that the ED was not the right environment for their presentation.
- There were also a number of positive experiences and these mainly occurred when participants were assessed by a Clinical Nurse Specialist (self-harm) or a psychiatric NCHD.
- Positive experiences were focused around the calm, unhurried nature of the assessment which reassured participants and facilitated their disclosure of sensitive and distressing information.
- Participants also recognised and appreciated the expertise of these nurses and doctors in responding to and managing their mental distress.

### Discharge and Referral

- On their last presentation, the majority of participants (n=39) were discharged from the ED, while 11 participants were admitted to a mental health unit or medical ward.
- A number of participants (n=8) reported being discharged from the ED without any referral to supporting organisations.
- Many participants who were attending a mental health service were referred back to that service; however, in some cases there was no follow-up from the mental health team or the follow-up was a few weeks away and not around the time of immediate crisis.



- Participants reported that when they were discharged from the ED, family members were often left unsupported and lacking information in how best to manage care for the person.
- There were also a number of positive experiences of discharge and follow-up from the ED. These mainly occurred when mental health staff telephoned them in the days following their ED attendance, which suggested to participants that they were important and not forgotten about.

### The Emergency Department Environment

- Almost all participants commented on the long waiting times in the ED. However, most did anticipate a long wait and were cognisant of the busyness of the ED staff.
- Rather than feeling they had arrived in a safe space, waiting in noisy, over-crowded waiting rooms appeared to heighten peoples' anxiety and emotional distress.
- Long waiting times increased participants' desire to leave the ED without assessment from a mental health professional.
- Participants who were on their own in the ED described the waiting time as difficult and lonely. The presence of a family member or friend for some encouraged them to stay and be assessed.
- The long waiting time also meant that by the time they were assessed, they were often too exhausted to engage meaningfully with the assessment.
- There was significant variability in the type of facilities available to people experiencing mental distress.
- A small minority reported being interviewed in a private room which enabled them to feel safe to disclose personal and sensitive information without worrying about being overheard.
- The majority however spoke about a lack of privacy as they were interviewed and assessed in an environment where their personal information could be overheard, or where people were coming in and out of the space they were allocated. This resulted in some participants being reluctant to disclose and discuss their distress.
- Being '*mixed in*' with people who had serious physical health issues including those requiring emergency treatment compounded many participants' beliefs that they were undeserving of care in the ED and that they were '*taking up a trolley*'.
- Many participants and particularly those who presented with suicidal ideation but without self-harm reported that the ED was not the appropriate environment for assessment and treatment, yet it was the place they were told to present to when in distress.



## Negative Experiences in the Emergency Department

- Participants were often made to feel *'different'* from others in the ED presenting with physical health problems.
- They perceived being labelled as a *'mental health presentation'* and being set aside from other patients.
- In some EDs, a special observation area was described which made them feel observed and stigmatised rather than making people feel safe.
- Participants reported that some staff attitudes, which were both implied and explicit, made it clear that their presentation in the ED was taking up space and taking time away from patients who they considered were *'more deserving'*.
- Many participants reported that as their mental distress was not visible in a physical sense, it was often minimised or not validated.
- Negative interpersonal interactions with ED staff were reported by many participants. These included negative comments, dismissive attitudes (e.g. being childish and attention-seeking), a judgemental/shaming approach and a reductionist approach to assessment, care and treatment.
- There was a lack of understanding around Personality Disorder diagnoses among non-mental health ED staff.
- Participants also reported a lack of understanding of self-harm and the functions of self-harm for people and again this was primarily among non-mental health staff in the ED.
- Participants highlighted the need for skilled personnel to carry out assessments of people who self-harm or have suicidal ideation as suicidal intent can be hidden and needs to be uncovered skilfully and compassionately.

## The Impact of Negative Experiences in the Emergency Department

- The negative experiences participants encountered had a deep impact on them. For many, it compounded a sense of shame they already had about their self-harm or suicidal ideation.
- Some participants described how the negative attitudes they experienced actually served to heighten their distress including negative thinking and feelings of low self-worth, and re-traumatised some who had already experienced trauma.
- These experiences left some participants wanting to leave the ED while others commented that they would not return to the ED if in distress again.

## Positive Experiences in the Emergency Department

- Despite the negative experiences outlined, almost all participants could identify some positive interactions or experiences which occurred in the ED.
- Most of these positive experiences related to positive interactions participants had with various staff within the ED, including ancillary staff (e.g. ambulance personnel, receptionists, porters etc.).
- Interactions with staff who were kind, helpful, reassuring and supportive were a strong indicator of whether participants had an overall positive experience of the care they received.
- In many instances, these positive interactions were not necessarily related to complex psychotherapeutic interactions, but rather to everyday respectful communication skills that demonstrated warmth, compassion and empathy.
- Interactions that were calm and unhurried were valued by participants, particularly when disclosing and discussing personal and distressing thoughts and feelings.
- Participants who were seen by a Clinical Nurse Specialist or other mental health professionals described a generally more positive experience in relation to their care and treatment.
- These staff were praised for their knowledge, attitudes and skills, but also for their autonomy which had an impact on participants' waiting time.
- Some EDs provided a quiet room for assessment and the privacy and confidentiality afforded to participants in these rooms were very positively received and had a significant impact on participants' willingness to disclose sensitive information.
- Some positive examples of aftercare and follow-up were provided which included prompt follow-up, helpful telephone calls from CNSs in the ED, good continuity of care between the ED and mental health services and good communication between the ED and GPs.
- Most participants presenting with self-harm reported that their physical injuries were very well managed.



## Improving Service Users' Experiences in the Emergency Department

- Most participants provided suggestions as to how their experiences in the ED could be improved.
- The availability of mental health staff to assess patients in the ED was identified as important. While many participants were seen by a mental health professional, some were not and in these instances the experiences were generally more negative.
- The availability of mental health staff in a timely manner out-of-hours was identified as important.
- The provision of a quiet, private room in which to be seen was reported as very important. The noise, overcrowding and general busyness of the ED was identified as making it difficult to disclose and discuss personal information.
- Many participants described the need for an 'emergency mental health department'. There were variations on the form this would take but many suggested a sub-division of the ED where patients in suicidal crisis and with acute emergency mental health needs could be treated.
- The provision of education and training, particularly to non-mental health staff, was regarded as an important improvement by participants. Participants acknowledged that staff in the ED are generally not trained in mental health and they did not expect them to be experts in mental health but they did believe that a certain level of knowledge was required which in turn could have an impact on the sometimes negative attitudes they experienced. Suggestions around the content of education included understanding the experience of people who are suicidal, understanding self-harm, and knowing 'what not to say' as much as knowing what to say.
- While education was viewed as important, it was also recognised that many of the positive interactions participants experienced were as a result of basic but good interpersonal skills – this included simply offering someone a warm drink and checking in on them periodically when waiting for long periods.
- Participants who were unaccompanied in the ED talked about the need for some kind of service that could support the person during the long waiting periods which often served to heighten distress and encourage the person to leave. Some participants were aware of a be-friending type service in which a volunteer would come and sit with the person if they wanted someone to wait with them. Some participants who hadn't heard of this service, also suggested something similar.
- Finally, participants recommended improvements in the referral and aftercare process and in particular in linking on to psychosocial supports.

## Key Recommendations

Based on the findings of this study the following recommendations are made:

### Referral, service provision and alternatives to the Emergency Department

- The ED can be an inappropriate treatment environment for people who present with suicidal ideation without requiring medical treatment. A 24/7 crisis mental health support service is required which allows those who present in mental health crisis to be assessed and treated by mental health professionals in a mental health specific setting. A crisis mental health support service should involve a number of components:
  - Crisis assessments carried out in the community setting.
  - For those who present without self-harm, consideration should be given to creating a setting that could be a sub-department of the ED or a distinct setting as part of the Community Mental Health Service.
  - For those who present to the ED following self-harm, the crisis support service should be available to them following treatment of their physical injuries.
  - Existing Community Mental Health Teams need to be adequately resourced and equipped with the facilities to provide crisis support as advocated in 'A Vision for Change'.
  - GPs require a crisis support service to refer people presenting in suicidal crisis other than the ED.
  - This crisis mental health support service should include the provision of 'crisis houses' again as flagged in 'A Vision for Change'.
- To reduce the need to attend the ED, people who are under the care of the mental health services should be provided with the contact number of an out-of-hours support to contact when in difficulty.
- All agencies involved in referring people to the ED should encourage people to bring a family/friend/companion with them if this is possible which may help alleviate the person's distress and encourage them to stay for assessment and treatment.
- The public discourse about the ED as the primary treatment setting for those experiencing a mental health crisis who have not self-harmed needs to be considered. Those experiencing a mental health crisis should be aware of the alternatives to the ED which may be suitable/available to them. Again, in cases where presentation to the ED is required, people should be encouraged to bring a family/friend/companion with them if this is possible.





- Participants in this study who were treated by staff as part of the NCP had generally more positive experiences. In the absence of 24/7 mental health crisis supports, the *National Clinical Programme (NCP) for the Assessment and Management of Patients Presenting to Emergency Departments following Self-Harm* should be adequately resourced to be available on a 24/7 basis and delivered in every ED in Ireland.

### Interventions and Care in the Emergency Department

- Continued implementation of and adherence to the principles of the NCP which aims to develop a standardised and effective process for the assessment and management of individuals of all ages who present to ED is required. In relation to assessments, the following recommendations are made:
  - A comprehensive standardised biopsychosocial assessment is required to be carried out by a mental health professional in a timely manner. However, while standardised, these assessments should also allow room for peoples' individual experiences and narratives.
  - Biopsychosocial assessments are required to be carried out in a compassionate and respectful way.
  - Assessments in the ED should not focus solely on assessing risk but also on safety planning including supporting people to identify current and future supports.
- Therapeutic and supportive interactions are required with those who present to the ED with self-harm and suicidal ideation. Specific recommendations here include:
  - The principles of Make Every Contact Count (MECC) should transfer to those presenting with mental health problems. These principles highlight the importance of healthcare staff making each routine contact they have with patients count. Presentation at the ED with self-harm and suicidal ideation offers the opportunity for staff to engage in brief advice and brief interventions to support patients in making health behaviour changes.
  - Every person interacting with people who present to the ED with self-harm and suicidal ideation are required to interact with individuals and their families in a compassionate manner being mindful of the potentially damaging effects of language used.
- In order to provide an immediate plan of care to someone presenting to the ED with self-harm or suicidal ideation, a collaborative emergency care plan should be developed with every person who presents. The person's next-of-kin should be included in this plan when possible. Although both are also recommendations from the NCP, for the majority of people in this study there was limited evidence that these plans were being developed, or if they were that patients were aware of them.

- Each person discharged from the ED following presentation with self-harm or suicidal ideation should receive follow up and bridging to next care:
  - In line with the NCP, each person discharged from the ED should receive a plan for next appropriate care.
  - It is required that family members are supported when a person is discharged from the ED. Information provided to them should include advice on suicide prevention, how to support their family member and where to seek help if a crisis emerges.
  - In line with NCP recommendations, each person should receive a follow-up call from a mental health professional following their ED attendance. Where these calls occurred, they were well received but many did not receive this follow-up.
  - Consideration could be given to developing a standardised Information sheet which includes information about self-harm reduction and suicide prevention in addition to information about national and regional help sources (e.g. Pieta, 'Your Mental Health' 24/7 information line, and the newly launched crisis text line.) which could be provided to people on discharge from the ED.

### **The Emergency Department Environment**

- While observation of people who are in a suicidal crisis and waiting to be seen is important, the physical environment of where they are observed should still offer some privacy from the public while allowing observation from staff.
- Provision of a quiet environment for assessment allows privacy and increases potential for disclosure of mental health difficulties. A quiet room for people who present with self-harm or suicidal behaviour is required for appropriate assessment.
- Particular attention is required to be paid to those who present unaccompanied to the ED as they are more likely to leave without being seen.
- Hospitals can consider the introduction of a 'be-friending' type service which offers people who present to the ED alone the opportunity of having a volunteer wait with them which was a positive interaction reported by some. This may also serve to reduce the number of people who leave without being seen which is an important objective.



- Due to the large amount of staff interacting with people presenting, healthcare professionals engaging with people presenting to the ED should inform them of who they are and their role in the person's care (e.g. Clinical Nurse Specialist – Self-Harm, NCHD etc.). This should be an extension to the current 'Hello, my name is...' campaign – an international campaign for more compassionate care which encourages healthcare staff to introduce themselves to patients which is supported by the HSE in Ireland as part of the patient engagement strategy.

### Education and Training for Emergency Department Staff

- To improve knowledge, understanding and attitudes towards people who engage in self-harm and experience suicidal ideation healthcare staff working in the ED who do not have a mental health background should be provided with basic key information which should incorporate:
  - Understanding self-harm and suicidal behaviour including from a sociocultural perspective.
  - Key skills for working with patients experiencing significant mental distress.
  - Education about the many potential functions of self-harm and an understanding that self-harm does not necessarily equate to a symptom of an illness but may reflect a rational coping strategy for an individual at a particular point in time.
  - Education on the implications of suddenly reducing access to self-harm.
  - Education on the importance of providing compassionate, empathetic responses in brief interactions with people presenting in suicidal crisis.
  - Information about the potential damage that language can do particularly when people are in crisis and already experiencing feelings of low self-worth. This education should focus just as much on 'what not to say' as on 'what to say'.
  - Education on the implications of labelling people with 'personality disorder' diagnoses and the impact this has on the person.
- The education and training requirements highlighted above have been identified as particularly relevant to staff who do not have a mental health background as it is assumed that mental health staff engaging with people who present to the ED with self-harm or suicidal behaviour will already have this education however frequent updates on some of these topics may be required for mental health staff.
- Education on interacting compassionately to those in suicidal crisis should also be provided to ancillary staff e.g. Gardaí, receptionist staff, porters, catering staff etc.

- Mental health staff within the NCP (CNSs, NCHDs) have received training in the assessment and care of people presenting to the ED with self-harm or suicidal ideation and therefore are ideally placed to offer brief interventions for education provision to non-mental health staff in the ED.
- Recognising the potential for burnout and compassion fatigue when working consistently with people in significant mental distress, mental health staff engaging frequently with people who present to the ED with self-harm or suicidal ideation should be offered and avail of clinical supervision.

#### Further Research

- Research is required on the experiences of family members/friends and carers when presenting with a person experiencing a suicidal crisis to the ED to establish how they can be better supported.
- Research is required on healthcare and allied staff perspectives of supporting someone presenting to the ED with self-harm or suicidal ideation.
- An observational study within the ED may facilitate understanding of care in context with a longitudinal perspective which would facilitate follow-up of people who present to the ED with self-harm and suicidal ideation.

## Chapter 1: Introduction and Background

### 1.1 Introduction

This chapter provides an introduction to some of the key issues relating to presentation to Emergency Departments with self-harm or suicidal behaviour. Included in this section is a brief overview of some of the national and international programmes relevant to this group in addition to an outline of some key literature relating to care and treatment of self-harm and suicidal behaviour in the ED.

### 1.2 Self-harm and suicidal behaviour in the Emergency Department

Self-harm and suicide are recognised as major public health issues both nationally and internationally (WHO, 2014; Department of Health, 2015), and disproportionately affect younger populations (Patton, 2009; Hawton et al. 2012). In Ireland in 2018, there were 12,588 presentations to Emergency Departments (ED) nationally for treatment of self-harm, involving 9,785 individuals. This represents an increase of 6% on the preceding year following a period of stabilisation of self-harm presentations. The highest rates of self-harm are among the younger population, being highest among women in the 15-19 age group and highest for men in the 20-24 age group. Some age-related trends in the 2018 data include an increase of 8% in the male rate of self-harm in 10-24 year olds, and a 47% increase in the rate of self-harm in women aged 65-69 years. Another trend is the increasing lethality of self-harm acts, particularly among women. Repetition of self-harm continues to be a significant issue with approximately one in five (2,803, 22.3%) of the presentations to the ED in 2018 being due to repeat acts. The risk of repetition was found to be greater in the days and weeks following a self-harm presentation to hospital and the risk increased substantially with each subsequent presentation (Griffin et al. 2019).

With regard to suicide, the most recent year of occurrence data from the Central Statistics Office shows that there were 437 deaths by suicide in Ireland in 2016, a rate of 9.2 per 100,000 of the population and that, consistent with figures over the years, the majority of these deaths were male (80%) (NOSP, 2019). Since 2010 the suicide rate is highest amongst those aged 45-54 at 14.2 per 100,000 (NOSP, 2018). In comparison to European countries, Eurostat data from 2015 and 2016 places Ireland as having the 11th lowest rate of suicide among 34 countries, however, among young people aged 15-19, Ireland ranks as having the 9th highest rate of suicide among 33 countries (NOSP, 2019).

Self-harm and suicidal behaviour are strong risk factors for future suicide. It is estimated that people who self-harm are 50 to 100 times more likely to die by suicide in the 12 months following a self-harm episode (National Institute for Health and Care Excellence (NICE) 2013). It is also predicted that one in 25 service users attending Emergency Departments for self-harm will die by suicide within the next 5 years (Carroll et al. 2014). Several studies have found a heightened risk of repeat suicidal behaviour and completed suicide in the period immediately following discharge from hospital (Larkin & Beautrais, 2010; Carroll et al. 2014). A UK study found that nearly half of suicide deaths happened within the month after discharge and just over 40% occurred before the first follow-up appointment (Hunt et al. 2009). Da Cruz et al. (2011) reported that approximately 40% of those who died by suicide had attended the ED in the year prior to death.





The Emergency Department therefore represents an important setting for suicide prevention and early intervention, particularly as it is often the first entry point to the health system for those who self-harm and it is a gateway to accessing follow-on services (Doyle et al. 2007; Egan et al. 2012; Doyle, Keogh & Morrissey, 2015). Attendance at the ED following self-harm or suicidal behaviour represents an opportunity for service users to receive treatment that will reduce the risk of repeat self-harm episodes and suicidal behaviours (Barr et al. 2004; Bantjes et al. 2017).

Psychosocial assessment is considered integral to the development of appropriate treatment plans and improved access to follow-up care for Emergency Department service users (Gkaravella, 2014). There is also some evidence of improved outcomes among service users who receive a psychosocial assessment and/or referral to follow-up services, with lower rates of self-harm repetition and suicidal attempts found (Mann et al. 2008; Buykx et al. 2012).

In the UK, NICE guidelines on the short term and longer term management of self-harm recommend that individuals presenting to the ED following self-harm should receive a comprehensive psychosocial assessment before discharge (NICE, 2004; 2011). A psychosocial assessment generally considers the underlying causes of self-harm or suicidal behaviour, the person's current level of distress and history of psychiatric illness, social supports, personal issues, and follow-up needs (Mullins et al. 2010).

In Ireland, a National Clinical Care Programme (NCP) for the *Assessment and Management of Patients Presenting to Emergency Departments Following Self-harm* was first introduced to the ED in 2014 (HSE, 2016; HSE, 2017). Its principle aim is to develop a standardised and effective process for the assessment and management of individuals of all ages who present to EDs of acute hospitals following an episode of self-harm or with suicidal ideation. Some core components of the NCP are a compassionate response to people presenting with self-harm and suicidal ideation, an expert biopsychosocial assessment, the development of an Emergency Care Plan, the involvement and support of Next of Kin (NoK), and follow-up and bridging to next care following discharge from the ED. The programme provides for the allocation of Clinical Nurses Specialists (CNS) to deliver the programme and training for psychiatry Non-Consultant Hospital Doctors (NCHDs) and emergency health care staff in working with those who self-harm or present with suicidal ideation. At the time of writing, there are 24 adult EDs operationalising the Clinical Care Programme and 2 EDs which have liaison mental health nurses in place (HSE, 2017). Working arrangements for CNSs in EDs in Ireland vary and the recommendation from the NCP is that these arrangements are adapted to best suit local needs (HSE, 2017). Current arrangements for service provision in place throughout the country include 9am to 5pm delivery Monday to Friday, 8am to 8pm delivery 7 days a week, and in some busier EDs a combination of hours up to 3am or providing 24 hour support. Assessment of patients who present out-of-hours when a CNS is not available is usually carried out by psychiatry NCHDs who are also trained in the NCP, with follow-up by the CNS. Clinical Nurse Specialists delivering the NCP are supported in their role by a supervising Consultant Psychiatrist.

Despite the existence of the NICE guidelines in the UK since 2004, inadequate management of people presenting to hospitals with self-harm is evident as not all service users receive a formal assessment prior to discharge (Hickey et al. 2001; Baraff et al. 2006). A study of service users attending an Emergency

Department in Ireland with a presentation of self-harm over 12 months found that 41% left without receiving a psychosocial assessment (Mullins et al. 2010). A more recent large-scale observational study examining trends in non-fatal self-harm in three centres in England found that between 2000 and 2012 just over half (53.2%) of service users received a psychological assessment (Geulayov et al. 2016). This is problematic as, in the absence of comprehensive assessment, clinicians will miss underlying issues contributing to self-harm behaviour and be unable to develop appropriate treatment plans, placing the service user at risk of repeat episodes of self-harm or suicidal behaviour (Conlon et al. 2012).

There is also evidence of marked variability in service provision for service users presenting to Emergency Departments with self-harm. Cooper et al. (2013) investigated trends in the hospital management of self-harm by 32 hospitals in the UK over a 10 year period from 2001 to 2010, and found that there was little change in the number of specialist assessments conducted, a significant increase in general hospital admission, and a decrease in referrals for specialist mental health follow up. In 2010, four out of ten individuals left hospital without having an assessment with a mental health specialist. In terms of positive change, an improvement in service quality over the 10 year period was evidenced in terms of the presence of a psychiatric liaison team within the ED, the provision of support, training and supervision for ED staff, regular multi-disciplinary management meetings being held, and better collaboration with primary care and non-statutory services. Similarly in Ireland, marked variation in recommended next care was found across hospitals in relation to the proportion of service users admitted to the presenting hospital, the proportion leaving before a recommendation and the proportion receiving a mental health assessment. Although overall 72% (n=8,490) of service users were assessed by a member of the mental health team in the presenting hospital in 2018, this figure varied considerably by hospital. The discrepancies are attributed to differences in the resources and services available to each hospital and also diversity in assessment and management protocols with regard to self-harm presentations (Griffin et al. 2019).

Failure to provide a psychosocial assessment may be due to a lack of clarity in guidelines as an initial review of the NICE guidelines concluded that they failed to indicate at what point the assessment should be conducted, whose responsibility it is to conduct the assessment, and which components should form the assessment (Pitman & Tyrer, 2008). Indeed, little is known about the content of psychosocial assessments carried out in EDs (Gkaravella, 2014), except that they are primarily led and informed by clinical judgement which results in variability in the quality of assessment of service users presenting with self-harm or suicidal behaviour in the ED (Randall et al. 2011). In terms of responsibility for conducting assessment, several studies found that while clinicians perceived that they had a role in psychosocial assessment and management, they largely eschewed this aspect of their work, focusing instead on the provision of medical care (Doyle et al. 2007; Conlon et al. 2012; Saunders et al. 2012). It is thought that the reason for this is that generic hospital staff regard psychological assessment and intervention as the responsibility of mental health care staff (Conlon et al. 2012) or in some cases they believed that didn't have the necessary skills to complete such an assessment (Keogh, Doyle & Morrissey, 2007). Indeed, Koning et al. (2018) found that Emergency Department personnel perceive that their primary role is to assess and treat service users' physical needs and that specialist staff with training in mental health are better equipped to carry out mental health assessment and intervention.



Service users may also not receive an assessment due to discharging themselves from the ED before one is completed (Hickey et al. 2001). Service users who present with self-harm have been found to be more likely to discharge themselves prematurely compared to other service users (Barr et al. 2004), thereby increasing their risk of future self-harm and suicidal behaviour (Hickey et al. 2001; Crowder et al. 2004). In 2018, 13% of service users left the Emergency Department in Ireland before a next care recommendation could be made and the majority of these did not receive an assessment. The proportion of service users leaving the Emergency Department before a next care recommendation could be made was greater in inner city hospital Emergency Departments, perhaps indicating the impact of busy ED environments on service users (Griffin et al. 2019). The fast paced and physical health orientated nature of the ED is considered ill-suited to person-centred care with a focus on mental health care needs (Conlon et al. 2012).

While the most common pathway for service users attending the ED for self-harm is discharge following treatment with referral or follow-up services, not all service users leave with follow up care plans while others have poorly coordinated care plans with significant delays in accessing services (Grimholt et al. 2012). Furthermore, the extent to which service users avail of these services and their experiences of these services is largely unknown in Ireland. The findings of a recent study by Cleary et al. (2017), who investigated the help-seeking patterns and attitudes to treatment amongst a sample of 52 men aged 18-30 who attempted suicide in Ireland, suggest that there is low uptake and a lack of confidence in follow-on services. In spite of the fact that all participants were discharged with a referral to psychiatric aftercare services, one-third never attended the out-patient department and 29% of those who did attend, did so for less than one month. Almost half of the sample made a subsequent attempt and 12% (n=6) completed suicide. Factors contributing to low take-up of services included a lack of awareness of psychiatric symptoms, reluctance to disclose distress, reliance on maladaptive coping strategies, such as self-medicating with drugs and alcohol, and negative attitudes relating to the efficacy of psychiatric/psychotherapeutic interventions.

Clinicians' attitudes about people who self-harm and their knowledge and skill in dealing with service users who self-harm will impact on their clinical practice and the quality of care they provide to this cohort (Saunders et al. 2012). Given the importance of the Emergency Department as a site for suicide prevention and early intervention, it is essential that people who attend ED have positive therapeutic interactions with staff and that staff possess the requisite knowledge and skills to respond effectively to people who present with self-harm or suicidal behaviour. The nature of the interactions between clinicians and services users following self-harm has important implications for service users' engagement and compliance with treatment, their prospects for recovery as well as future help-seeking or self-harming behaviours (Rees et al. 2014; Raynor et al. 2018).

Although several Irish studies have shown that Emergency Department nurses hold largely positive attitudes towards people who self-harm in terms of having empathy and compassion for them (McCarthy & Gijbels, 2010; Conlon et al. 2012), studies have also highlighted the existence of negative attitudes, with instances of Emergency Department nurses critically appraising the morality or authenticity of service users' actions, which in turn affected how responsive staff were to their needs (Doyle et al. 2007; Conlon et al. 2012). These studies also documented a lack of skills, knowledge and training among clinicians in caring for people who self-harm (Doyle et al. 2007; Keogh, Doyle & Morrissey, 2007; Conlon et al. 2012).

Evidence from international literature echoes these findings with several studies finding that Emergency Department nurses hold negative attitudes towards service users who self-harm (McAllister et al. 2002; Mackay & Barrowclough, 2005; Friedman et al. 2006). A recent meta-analysis examining Emergency Department nurses' attitudes towards service users who self-harm concluded that negative attitudes were present among staff. Five studies which measured attitudes using validated scales were included, two of which were from Ireland (Raynor et al. 2018). Similarly, a systematic review of international literature on clinical staff's attitudes towards people who self-harm found negative attitudes were prevalent, particularly towards those who repeatedly self-harmed, and were comparatively worse than attitudes towards most other service users whose health care needs were seen as more legitimate. Negative attitudes comprised feelings of irritation, anger and frustration towards those who self-harmed and were found to be most pronounced in the general medical setting, including the Emergency Department (Saunders et al. 2012). Although studies have found that emergency care staff display empathy towards those who self-harm, they also found that they experience a sense of frustration and powerlessness when confronted with service users who repeatedly self-harm (Rees et al. 2014; Martin et al. 2014). An expectation that repeat self-harm is likely leads to less optimism and helping behaviour among Emergency Department staff (Mackay & Barrowclough 2005). As well as experiencing frustration with the person who self-harms, Emergency Department staff's frustration is also borne out of the failings of the system to provide effective responses to people who self-harm, with service users often re-attending within a short space of time, and their own lack of knowledge, confidence and skill in dealing with people who self-harm (Doyle et al. 2007; Egan et al. 2012; Rees et al. 2014; Koning et al. 2018). Saunders et al. (2012) found that clinicians lacked knowledge of high risk groups and the incidence of mental illness among people who self-harm.

Several factors have been identified as influencing clinicians' attitudes towards people who self-harm, including education and training, experience with and exposure to service users presenting with self-harm/suicidal behaviour, knowledge, confidence, demographics, and setting (Rees et al. 2014; Raynor et al. 2018). Many clinicians have very little training in treating service users with self-harming behaviour leaving them feeling unskilled and uncertain (Friedman et al. 2006). It has also been reported that ED staff are working in environments where they have little access to training or departmental guidelines (Rees et al. 2014)

A lack of knowledge, confidence and skills among nurses in dealing with people who self-harm increases antipathy towards this cohort and can adversely affect the quality of care they receive (McCann et al. 2007; Conlon et al. 2012). People who present to the ED with self-harming or suicidal behaviour may be ignored and not receive urgent attention because of negative views relating to them being timewasters and attention-seekers, not being regarded as having legitimate health care needs compared to other service users and being perceived as difficult to deal with (Conlon et al. 2012; Rees et al. 2014).

The negative attitudes evident among clinicians is reflected in service users' accounts of receiving care for self-harm or suicidal behaviour in the ED. Service users' experiences of emergency care have been widely reported as negative, owing largely to ED clinicians' lack of knowledge and sensitivity to the needs of those with self-harm and suicidal behaviours (Horrocks et al. 2005; Taylor et al. 2009; Shand et al. 2017; Lovelace et al. 2017). A summary of a review of the literature relating to service users' experiences of presenting to Emergency Departments with self-harm and suicidal behaviour is presented in Chapter 2.

## Chapter 2:

# Summary Literature Review – Service Users’ Experiences of Presenting to the Emergency Department with Self-Harm and Suicidal Behaviour

## 2.1 Introduction

This chapter provides a summary of a review of international literature relating to service users’ experiences of presenting to the ED with self-harm and suicidal behaviour.

## 2.2 Service Users’ Experiences of Presenting to the ED with Self-Harm and Suicidal Behaviour

Within the International literature, service users report encountering negative attitudes and behaviours from clinicians in the Emergency Department, including stigmatising views about self-harm, a lack of empathy for service users, and not listening to or respecting the needs of service users (Cerel et al. 2006; Larkin, 2013; O’Connor 2015; Owens et al. 2016). The literature describes service users experiencing ‘stigmatising’, ‘punitive’, ‘humiliating’ ‘inconsiderate’, ‘indifferent’, ‘impersonal’, ‘infantilising’ and ‘judgemental’ attitudes and behaviours from clinicians (Harris, 2000; Brophy, 2006; Palmer et al. 2007; Graham, 2012; Larkin, 2013; O’Connor, 2015; Owens, 2016; Kuehl, 2017; Lindgren et al. 2018). Service users perceive that clinicians regard them as less deserving of treatment compared to other service users due to the self-inflicted nature of their presentation and that this results in comparatively poorer care provision (Horrocks et al. 2005; Taylor et al. 2009; Larkin, 2013; O’Connor, 2015; Owens et al. 2016). Service users recount punitive responses from clinicians, such as withholding treatment related to physical injuries or neglecting service users’ physical, emotional, mental health and social needs (Horrocks et al. 2005; Brophy, 2006; Palmer et al. 2007; Graham, 2012; Hunter et al. 2015; Holliday & Vandermause, 2015; Owens et al. 2016; Lindgren et al. 2018).

Service users who present to the Emergency Department have many negative self-evaluations, such as feelings of worthlessness, shame and guilt, and are acutely aware of being a burden on already overwhelmed services (Hunter et al. 2013; Larkin, 2013; Holliday & Vandermause, 2015; Owens et al. 2016; Walker, 2017). When they encounter negative attitudes and behaviours from clinicians, these negative self-evaluations are then reinforced and confirmed (Larkin, 2013; O’Connor, 2015; Owens et al. 2016). Services users report that their experience of emergency care is dependent on who the treating clinician happens to be and their personal approach to care rather than any systematic approach to care (O’Connor, 2015; Walker, 2017). In addition to negative attitudes among clinicians, they also demonstrate a lack of knowledge of self-harm and suicidal behaviour, and how to respond appropriately (Horrocks et al. 2005; Taylor et al. 2009; Shand et al. 2017). This is apparent from their medical approach to self-harming and suicidal behaviour rather than engaging with it from a psychosocial perspective (Horrocks et al. 2005).

The literature also highlights the lack of information, communication and involvement in care throughout service users’ attendance in the Emergency Department (Horrocks et al. 2005; Palmer et al. 2007; Taylor et al. 2009; Owens et al. 2016; Kuehl, 2017). Service users’ accounts of Emergency Department care describe a strong feeling of abandonment when they have to endure lengthy waiting periods for treatment without contact, information or reassurance from clinicians. Service users feel that this delay is indicative of their distress not being duly acknowledged or considered a priority (Horrocks et al. 2005; Palmer et al. 2007).





Consent for treatment is not always sought by treating clinicians, instead service users experience involuntary and coerced treatment with threats being issued by clinicians (Brophy, 2006; Taylor et al. 2009; Donley, 2015; O'Connor, 2015; Walker, 2017). This kind of treatment is experienced as disempowering for service users (O'Connor, 2015). Clinicians' attempts to understand service users' behaviours are sometimes times rushed, clumsy, and frustrated attempts which do not duly consider the person's present state, their ability to engage, the presence of trust in the clinician-service user relationship or the impact of reliving painful events (Horrocks et al. 2005; Walker, 2017). This approach also does not take into account the fact that service users may be wrestling with their own struggles with disclosures around self-harm and suicidal behaviour, especially if they have been invested in concealing that behaviour from family and others (Owens et al. 2016). Furthermore, discontinuity in care within Emergency Departments often requires service users to repeat information to different clinicians which does not facilitate the establishment of positive therapeutic relationships and adds to service users' distress (Palmer et al. 2007; Donley, 2015; Kuehl, 2017).

The purpose of psychosocial assessments is not well understood among service users and is regarded by some as a futile exercise with no positive outcomes (Hunter et al. 2013). For others, the psychosocial assessment is experienced as a formality conducted without sensitivity or any genuine therapeutic engagement with the service user with a view to addressing their psychosocial needs and care planning in a collaborative manner. Instead, many service users regard it as a futile, non-beneficial, tick-box exercise designed as part of an overall aim to process individuals through the system as quickly as possible (Horrocks et al. 2005; Graham, 2012; Hunter et al. 2013; Owens et al. 2016; Kuehl, 2017). For some service users this processing precipitates discharge before they are ready and when they are still in need of immediate support (Palmer et al. 2007; Graham, 2012). Service users' input into aftercare planning is also minimal (Palmer et al. 2007) with evidence that clinicians base their plans on misassumptions (Horrocks et al. 2005), resulting in inappropriate aftercare plans which do not meet the individual's complex psychosocial needs (Hunter et al. 2013; Donley, 2015). Discharge plans are also poorly coordinated with unclear pathways to accessing aftercare services, and the onus for accessing follow-up care sometimes being placed on service users in spite of the fact that they may have diminished capability to proactively pursue follow-up care following a self-harm or suicidal attempt (Hunter et al. 2013; McKay & Shand, 2018). The lack of available services or long waiting times for access to services also contributes to poor follow-up care for service users (Palmer et al. 2007; Donley, 2015; McKay & Shand 2018). The lack of collaborative care planning and difficulties with accessing aftercare services perpetuates a cycle of inappropriate care for people with self-harming and suicidal behaviours (Hunter et al. 2013; McKay & Shand, 2018).

Many features of the Emergency Department environment cause distress for service users. There are lengthy waiting times to be seen (Horrocks et al. 2005; Palmer et al. 2007; Donley, 2015; Kuehl, 2017; Walker, 2017). The open layout makes privacy and confidentiality difficult to attain with treatment occurring within earshot and sight of other service users leaving service users feeling vulnerable and exposed (Horrocks et al. 2005; Palmer et al. 2007; Donley, 2015; Kuehl, 2017; Walker, 2017). The levels of noise mean that service users have to repeat information in order to be heard, adding to fears regarding confidentiality (Donley, 2015; Walker, 2017). Safety concerns have also been raised with service users being left in the presence of means to engage in further self-harm (Palmer et al. 2007; Walker, 2017)

These negative experiences and outcomes increase reticence to accessing Emergency Department care, with many only doing so as a last resort, and reduce future help-seeking behaviours (Palmer et al. 2007; O'Connor, 2015; Owens et al. 2016; Shand et al. 2017; Kuehl, 2017). They can also exacerbate distress and hopelessness among service users, and increase the risk of premature discharge, and future self-harming and suicidal behaviours (Palmer et al. 2007; O'Connor, 2015).

Many of the aforementioned studies also highlight that service users' experiences of care in the Emergency Department can be improved through positive interpersonal interactions, therapeutic engagement and collaborative care planning (Graham, 2012; Hunter et al. 2013; Donley, 2015; Lindgren et al. 2018). Service users highlight how small acts of kindness by clinicians, such as providing a cup of tea, being empathetic and respectful, being non-judgemental, providing reassurance, chatting informally, keeping them informed and treating them 'like a person' could alleviate some of their distress related to fears about being stigmatised and being burdensome to the service (Horrocks et al. 2005; Taylor et al. 2009; Graham, 2012; Donley, 2015; O'Connor, 2015; Owens et al. 2016; Kuehl, 2017). Clinicians need to be aware of and sensitive to the low feelings of people who present with self-harm or suicidal behaviour and challenge any negative feelings that they may harbour about themselves and their worthiness of treatment (Hunter et al. 2013). They also need to acknowledge service users' distress and be attentive to their emotional, mental health and social needs, not just their physical needs (Brophy, 2006; Graham, 2012; Owens et al. 2016).

The therapeutic potential of the psychosocial assessment is highlighted provided it genuinely engages with service users and explores the issues that contributed to their self-harm or suicidal behaviour at a pace acceptable to the service user (Hunter et al. 2013; Taylor et al. 2009; O'Connor, 2015; Owens et al. 2016). Furthermore, it must be followed up with collaborative decision-making in care planning to ensure that care plans are appropriate and person centred, and that attention is given to their feasibility and implementation (Taylor et al. 2009; Graham, 2012; Hunter et al. 2013; Lindgren et al. 2018). These processes can be empowering for service users, imbue them with hope and facilitate recovery (Graham, 2012; Hunter et al. 2013). Service users with self-harm or suicidal behaviour also require timely access to care, continuity in care, more accessible care and consent being sought for treatment (Horrocks et al. 2005; Lindgren et al. 2018; Kuehl, 2017).

Although the issue of how service users experience the ED has been explored internationally, at the time of writing we have been unable to find any published studies that explored the experiences of service users who present to Emergency Departments in Ireland following an episode of self-harm or suicidal ideation. While the clinical management of self-harm in the ED is gradually improving in Ireland (Griffin et al. 2019), there is still a cohort who leave hospital before a next care recommendation is made and considerable variation in treatment pathways from hospital to hospital. As one of the most important aspects of caring for service users who present with self-harm/suicidal behaviour is conducting an initial biopsychosocial assessment prior to either discharge or referral to other services, it is important to understand people's experience of this in the ED and factors that may contribute to premature discharge from ED care. Investigating and understanding the experiences of service users is critical to improving the management of people who self-harm and to the possible reduction of repeated self-harm and suicide.

## Chapter 3: Overview of Research Methods

### 3.1 Introduction

This chapter presents the aims and objectives of this study and the study methodology. It provides an overview of the sample and how they were accessed and recruited. It sets out the procedures for collecting and analysing the data and the ethical issues that were considered in this study.

### 3.2 Aim and objectives

The aim of this study was to explore the experiences of service users who present to the Emergency Department for treatment of self-harm and suicidal behaviour.

Objectives:

- To explore service users' perceptions of care in the Emergency Department following presentation with self-harm or suicidal behaviour;
- To explore service users' satisfaction with physical and psychosocial assessment and treatment, discharge, referral and after-care, and satisfaction with ED staff;
- To identify how the Emergency Department experience can be improved for service users who self-harm or experience suicidal ideation.

### 3.3 Research approach

This study employed a descriptive qualitative design to meet the aim and objectives. Qualitative research is directed at providing an in-depth and interpreted understanding of the social world of research participants by exploring their experiences and perspectives (Ormston et al. 2014). Descriptive research helps to provide a rich, straight description of an experience or event (Doyle et al. 2019) and is particularly useful to explore areas about which there is little known. The end product of a qualitative descriptive study is a description of participants' own experiences in language similar to that used by participants (Doyle et al. 2019). Throughout the presentation of findings in Chapters 4-10, participant quotes are used to illuminate the phenomenon under investigation and to demonstrate how the findings are grounded in the data.

### 3.4 Sample and Recruitment

The sample obtained in this study was a volunteer purposive sample. Participants were sought who had experience of presenting to the Emergency Department with self-harm or suicidal behaviour.



#### Inclusion criteria:

- Participants who presented to the Emergency Department for self-harm/suicidal behaviour more than 3 months ago, but within the past 5 years, irrespective of whether they stayed to be assessed or not.
- Participants who presented to the Emergency Department in the Republic of Ireland.
- Participants aged 18 years of age and over.

#### Exclusion criteria:

- Participants who presented to the Emergency Department for generic mental health problems and not specifically for self-harm or suicidal behaviour.
- Participants who presented to Emergency Departments outside the Republic of Ireland.
- Participants who presented to the Emergency Department more than 5 years ago or less than 3 months ago.
- Participants under 18 years of age.
- Participants who the research team consider are unable to give informed consent at the time of the interview.

The sample was recruited through a national advertising campaign which was conducted largely online through platforms including Twitter, Facebook, Instagram and Activelink and through advertisement in the health supplement of national newspapers. Organisations involved in the area of mental health and self-harm/suicidal behaviour were asked to send a link to information about our study through their social media channels. Potential participants who were interested in taking part in the study were then asked to make contact directly with the Principal Investigator (Dr Louise Doyle) to find out more about the study. If participants were amenable to receiving more information, an information sheet was sent out to them via their preferred medium (email or post). If they wished to take part in the study they then contacted the researcher and arrangements were made for the interview.

Expressed interest	Total interviewed
n = 78	n = 50

Table 3.1 Number of interview participants

### 3.5 Data Collection

Qualitative data were collected using individual semi-structured interviews. A total of 50 in-depth interviews were conducted over a 15-month period with participants from across Ireland which is a very large sample for a qualitative study and produced a large body of data. 26 of these interviews were face-to-face interviews, while 24 were conducted over the telephone at the participant's request. Each interview was audio-recorded and transcribed by a professional transcription company.

### 3.6 Data Analysis

Qualitative data were analysed using thematic analysis guided by Braun and Clarke's Analytical Framework (Braun & Clarke, 2006). This involved coding the data, identifying themes and relationships, and identifying differences between various participants.

### 3.7 Ethical Considerations

Ethical approval to conduct the study was granted by the Faculty of Health Sciences Research Ethics Committee, Trinity College Dublin. All involved with the study were bound by national and international codes of practice in research, and by professional standards within their disciplines. The rights and dignity of participants were respected throughout by adherence to models of good practice relating to recruitment, voluntary inclusion, informed consent, privacy, confidentiality and withdrawal without prejudice. An information sheet and consent form outlining the aim, objectives and procedures of the study was given to all potential participants in advance of the interviews. Informed consent forms were signed prior to undertaking the interviews. For face-to-face interviews, the consent forms were signed on the day of data collection. For telephone interviews, the consent forms were posted or emailed (at the participant's preference) to the researcher in advance. Verbal consent was also provided immediately prior to the interviews being conducted. Any questions pertaining to the study and participants' rights were answered by the researcher conducting the interview. The voluntary nature of participation was emphasised throughout the data collection process and participants were reminded that they were free to withdraw from the study at any time without fear of penalty.

The researchers were mindful of the sensitive nature of the topic and the upset it may cause to recount difficult experiences. If service users became upset during the interview, they were afforded the opportunity to stop the interview. However, no participant wished to stop the interview. The researchers are experienced mental health clinicians and researchers and were able to provide support in the first instance if the participants became distressed or upset and a list of support services was available to participants if they required it. All identifying information was removed from the qualitative data and participants were assigned a code number. In the report of the study, no reference is made to individual names or locations that could identify the participant. Data were password-protected and stored in accordance with the Data Protection legislation.



## Chapter 4: Presentation to the Emergency Department

### 4.1 Introduction

This chapter sets out a number of descriptive findings relating to participant demographics, the type of self-harm or suicidal behaviour they presented with, their pathway to the ED, the health professionals they saw in the ED and their overall perceptions of their experience in the ED.

### 4.2 Demographics

A total of 50 participants (39 females and 11 males) participated in this study. Participants were drawn from across the Republic of Ireland with each of the 4 provinces represented with the majority coming from Dublin. The age range of participants was 19 years to 68 years with a mean age of 35 years overall, 34 years for women and 41 years for men. 13 participants were married while the remainder had a relationship status of 'single', 'in a relationship', 'widowed' or 'separated'. 15 of the participants were parents. A total 35 participants identified attending a mental health service currently or in the past and 29 participants reported presenting more than once to the ED. As can be seen in Table 4.1, the majority of participants were in paid employment while Table 4.2 reports the educational qualification of participants.

Employment Status	Number
In paid employment	26
Unemployed	7
Student (incl part-time courses)	13
Other (e.g. volunteer, retired, working in the home)	4
Total	50

Table 4.1 Employment Status

Education Level	Number
Completed 2nd level	17
Currently in 3rd level	7
Completed 3rd level	20
Post-graduate qualification	4
Not specified	2
Total	50

Table 4.2 Education level



There are 26 adult Emergency Departments in the Republic of Ireland. As can be seen in Table 4.3, there was a wide spread of Emergency Departments represented in this study (n=21), with only 5 EDs having no-one presenting there. As 10 participants reported attending more than one ED, the total number of EDs presented to is higher than the number of participants. The EDs most represented in this study were two Dublin based hospitals; St James's Hospital (n=10) and Tallaght University Hospital (n=8) which it should be noted do not currently run the National Clinical Programme for presentations to the ED with self-harm.

Emergency Department Attended	Number of Presentations
St James's Hospital, Dublin	10
Tallaght University Hospital, Dublin	8
St Vincent's University Hospital, Dublin	5
Naas General Hospital, Naas, Kildare	5
University Hospital, Limerick	4
Connolly Hospital, Blanchardstown, Dublin	3
Midland Regional Hospital, Mullingar Hospital, Westmeath	3
Cork University Hospital	3
University Hospital Kerry, Tralee	3
Beaumont Hospital, Dublin	2
Wexford General Hospital	2
Cavan General Hospital	2
University Hospital Galway	2
South Tipperary General Hospital, Clonmel	2
University Hospital, Waterford	2
Mater Hospital, Dublin	1
Our Lady's Hospital, Navan, Meath	1
St Luke's Hospital, Kilkenny	1
Letterkenny University Hospital, Donegal	1
Mayo University Hospital	1
Sligo University Hospital, Sligo	1
Midland Regional Hospital, Portlaoise Hospital, Laois	0
Midland Regional Hospital, Tullamore Hospital, Offaly	0
Our Lady of Lourdes Hospital, Drogheda	0
Portiuncula University Hospital, Ballinasloe, Galway	0
Mercy University Hospital, Cork	0
Total	62

Table 4.3 Attendance at Emergency Departments

### 4.3 Type of self-harm/suicidal behaviour and antecedents

Participants reported presenting to the Emergency Department with a variety of self-harm and suicidal behaviours. Many participants presented to the Emergency Department feeling suicidal or with thoughts of suicide without actually having engaged in self-harming behaviour at that point (n=22). Most of these participants did not require any medical care and were presenting for psychological assessment and treatment or referral. Some of these participants were in an immediate suicidal crisis and required immediate assessment:

I knew I was in trouble, you know. I needed help quickly or something bad was going to happen. I couldn't keep myself safe. Or I felt I couldn't anyway. So I did what she [GP] suggested and went to A&E. ED23

However others did not feel they were immediately in danger but were nonetheless referred to the ED for assessment:

I was having thoughts of kind of self-harming and suicide. So she [GP] just said straight away the best way to be involved in the services is to present to A&E. So she wrote me a letter and I went up. And it was quite dramatic then after that, they obviously took it quite seriously when I was up there. Even though I wasn't actively suicidal or actively self-harming at the time. ED13

As explored later in these findings, the experience of presenting with psychological distress without physical care needs had the effect of participants being made to feel very different from other patients who were visibly sick.

A significant cohort of participants also presented to the ED having engaged in actual self-harm. Self-harm behaviours reported primarily consisted of overdosing and self-cutting, and in these situations participants required both psychological and medical assessment and treatment. For some of these participants self-harm was identified as a way of managing the distress they were feeling and served as an outlet for psychological pain:

Self-harm became a way to deal with really difficult feelings and emotions to do with my mood but also to do with how I felt about my body...because self-harm has been a coping mechanism for me. I have to be really careful about what I say because self-harm for me isn't a cry for help. It isn't to get attention, it's not for any of those things, it's something very private to me. ED04

For others, there was a clearly identified desire to end their life at that time:

I began planning ways of committing suicide. I basically got in the bathtub one night and slashed both my legs and took a massive overdose of everything from pain relief to benzodiazepines combined with alcohol. I text my friend saying I'm really sorry and she knew something was wrong. ED1

I was in a desperate, desperate state. I just wanted to die. ED03



Most participants discussed what led to the self-harm or suicidal ideation and a variety of different factors were reported which heightens the need to be aware of the individual nature of self-harm and suicidal ideation. Many participants reported how existing mental health problems like depression, anxiety and eating disorders contributed to their self-harm/suicidal behaviour:

I've had depression for years. Since my 20s really. And I have been having treatment but this is the worst it's been. ED41

In addition, negative life experiences including emotional, physical and sexual abuse and the psychological impact of these experiences were reported to contribute to self-harm/suicidal behaviour. For some, these experiences were historical and occurred in the past:

I was struggling with PTSD, I was struggling with flashbacks. I was struggling with memories from my childhood and stuff that was very, very hard. And I was beginning to be depressed and kind of be a big drain on the people around me. ED34

For others however, these experiences were quite recent events:

I was in quite an abusive relationship at the time, mentally abusive and it did turn physical. The night it happened I had a fight with my boyfriend and he was pushing me towards it. ED01

#### 4.4 Pathway/referral to the Emergency Department

There were three primary pathways for presentation at the ED (for their last reported presentation) and these were self-presentation following referral by a General Practitioner (GP), self-presentation where individuals either self-referred or were brought by a concerned family member/friend and presentation via ambulance called by the person themselves, a family member/friend or by a member of a river patrol unit. (Table 4.4)

Pathway to the Emergency Department	Number
Self-presentation following referral by GP	22
Self-presentation following self-referral (incl with family/friend)	14
Presentation via ambulance (called by family/friends, person themselves, river patrol unit)	11
Self-presentation following referral by mental health team	3
Total	50

Table 4.4 Pathway to the ED

Twenty-two participants reported being referred by their GP following presentation at their surgery. In these cases, GPs wrote a referral letter which accompanied the person to the ED. Most of these participants had presented to their GP and disclosed feelings of very low mood and suicidal thoughts but had not at that time engaged in any self-harm or suicidal behaviour. The majority of participants spoke of having a good relationship with their GP and trusted their referral to the ED but also identified how in many instances GPs referred to the ED identifying that this was the quickest way to access mental health assessment and services:

It was on the advice of my GP, she was just, I guess she was worried that I was heading down a scary road I suppose. And she wanted me to get in and get seen. Because the waiting [for an appointment] I suppose was really long. So her plan was to go in through A&E. ED09

Another participant reported being in a 'downward spiral' for some time and was considering suicide. She presented to her GP who referred her to the mental health services, however, the appointment she received was six months away:

Six months was the referral, Yeah. So the GP then advised me that basically the quickest way to get into psychiatry was to present at A&E and it was something I was quite reluctant to do. ED33

Two participants reported having been seen by a Suicide Crisis Assessment Nurse (SCAN nurse) in the primary care setting:

So I went to my GP and told them how I was feeling. How low I was. They said they were going to refer me to a crisis nurse. A crisis suicide nurse or something like that, they'd come there and see me the next day. And they did. She assessed me and she was lovely. But she felt that I needed to go to the A&E. ED49

The second main pathway was self-presentation where a person either self-referred to the ED or were brought by a concerned family member/friend (n=14). One participant described how a friend brought her to the ED following an episode of self-harm as she did not want an ambulance coming to her house:

I refused to get an ambulance. I refused. I didn't want that attention brought to the house. So she [friend] just wrapped me up as best she could and got a taxi to the hospital. ED01

The third main pathway to the ED was presentation via ambulance with 11 participants presenting in this manner. In the majority of these cases, participants were brought in by ambulance having been found by family or friends following a suicide attempt or serious self-harm. In a small number of cases, individuals themselves called the ambulance and in two cases (in two different areas of the country) the ambulance was called by volunteers on a river patrol unit who patrol some rivers within Ireland for people who show signs of experiencing a suicidal crisis:

I had been pulled off the railings of the river. I had slit my wrists and I'd seriously overdosed. But there's a patrol team that patrols the rivers, just a voluntary team that kind of watch out for people that might be down by the river so luckily enough they had come over to me when I was at the railings and called an ambulance. ED34



Outside of these three main pathways, a small number of participants (n=3) who were already attending the mental health services presented to the ED department on the advice of someone in their mental health team:

The only reason I didn't follow through [on a suicide plan] was because my mental health nurse rang me as I was getting the bus to [names place where the participant intended to die by suicide] and kind of talked me into going to A&E. ED37

Just over two-third of participants (n=32) were accompanied by a family member or friend for some or all of their time in the ED. Those who were unaccompanied in the ED (n=18) gave many reasons why, including that partners/family members were required to mind children at home, or to be in work and also that they did not want anyone knowing about their self-harm/suicidal behaviour:

Yeah I was ashamed, really ashamed do you know. And my family would be very close minded in terms of mental health and stuff like that. ED13

The impact of waiting in the ED while unaccompanied is an important finding in this study and is further reported on in Chapter 6.

#### 4.5 Who did they see in the Emergency Department

There was a large degree of uncertainty amongst participants about who specifically they were seen by in the ED. Most participants reported seeing a triage nurse who did an early assessment of their presenting problem and reported also being seen by a medical doctor. The extent of interaction with the medical doctor was determined to some degree by whether they were presenting with any medical injuries. Participants were specifically asked if they were seen by a mental health professional including self-harm nurses, liaison mental health nurses or psychiatric NCHD. While again most reported being assessed by a mental health professional, for many there was a great deal of confusion as to who they were and some participants were not sure if the person assessing them was a mental health professional:

I saw a few different people. Definitely the triage nurse and then a doctor but then I saw another person. They were some kind of mental health person I think but I am not sure. There were so many different staff there it's hard to know who is who. ED50

This confusion about who they saw in the ED is understandable for a number of reasons; firstly, participants were attending the ED at a time of deep distress and their recollection may have been impacted by this. Furthermore, the impact of medications/substances taken on overdose also made recollection difficult. In addition, it is difficult for lay people presenting to the ED to understand the various grades and disciplines of nursing and medical staff. All participants were asked if they had been reviewed by Clinical Nurse Specialists or 'self-harm nurses'. 14 specifically recall being seen by these staff, 21 said that they were not reviewed by a self-harm nurse and 15 were not sure. Of those who were not sure, it was apparent from their descriptions of their experience that many were actually seen by a self-harm nurse.

## 4.6 After the Emergency Department

The majority of participants were discharged following assessment/treatment in the ED (n=39). Many were discharged with some follow-up plan including a referral back to participants' mental health team or General Practitioner, however, 8 participants reported receiving no follow-up plan. Participants' views of the discharge process are discussed in the next chapter. A total of 8 participants were admitted to a mental health unit from the ED, with 3 further admissions occurring in the weeks after presentation to the ED and 3 participants were admitted to a medical ward for treatment of their self-harm, which in all cases was an overdose.

## 4.7 Overall perception of experiences in the Emergency Department

Participants were asked how they perceived their experiences in the ED. Half of the participants reported that they had an overall negative experience (n=25), 7 reported a generally positive experience and 18 reported mixed experiences. Participants who reported having mixed experiences comprised those who had both positive and negative experiences within the one presentation, but also those who had more than one presentation to the ED and reported good experiences in one presentation/location and bad experiences in others. The reasons for the negative and positive experiences are explained in the proceeding chapters. It is important to note, however, that even for those who reported an overall negative experience, most were able to identify some positive interactions within their overall experience.



## Chapter 5: Interventions and Care in the Emergency Department

### 5.1 Introduction

This chapter reports on the experiences of participants in relation to two key aspects of their care in the Emergency Department:

- Assessment and treatment
- Discharge and referral

### 5.2 Assessment and treatment

Participants were asked about the assessment they received in the ED. Generally, participants' experiences of assessment in the ED were largely negative. One of the most common responses was that the assessment was seen as very formulaic and a 'tick-box' exercise and not as an individualised assessment. This was particularly the case when assessments were carried out by non-mental health staff:

I remember him going through the questions and just thinking like what has any of this got to do with where I am? You are not actually asking me about what's wrong or what's going on. There was no open ended question – just have you done ABCD. ED2

I suppose I feel they're ticking the boxes, they're not **really** wondering how I am. ED10

There was a perception that some ED staff did not seem entirely comfortable asking questions about mental health and this came across in how the assessment was carried out:

Some of them are nice but they like, we can't help you because we don't know what we're dealing with. And they're scared to say anything; the younger ones in particular are petrified of saying the wrong thing. So they don't say anything and they ignore you. I started to think that they hated me because they don't explain that they're just scared and don't want to say the wrong thing. ED19

You could almost sense them going through the checklist of what they have to ask you in their head because it's that obvious they are not comfortable in doing a mental health assessment. ED04

Participants understood that staff were very busy, however, there was a feeling that the assessment was rushed:

It was quite a cold exchange in a way. Like it felt like somebody who wanted to get it done as soon as possible. ED16



They are just at a point where they have so many people they have to get through, patients assigned to them so they are just kind of at a point where they just need a quick answer. But with something like mental health – it's so personal that it does not work in this case. ED05

The rushed and mechanical nature of the assessment meant that at times participants did not feel comfortable disclosing personal feelings:

She [doctor] asked 'ok, what crisis led up to this', and I'm thinking I met you two minutes ago, you know, I'm not just gonna spill my guts to you now. They are obviously time constricted and they don't have time to stay there to hear your story so I would have been very restricted in my answers. ED36

It looked like he's [doctor] after being on a thirteen hour shift and you could see he wasn't really listening to you because he didn't raise his head up once to you. He was just writing. You know when someone's warm towards you, when someone's genuine. And you just know when someone doesn't have an interest in what you're saying and what you're trying to explain to them. ED15

Participants largely understood that certain questions had to be asked but identified that the way these questions were asked was important:

You have to answer lots of questions and some of them are hard to answer. It's very personal to talk about what has happened and what you've done. But the way they talk to you about it, the way they ask the questions is important. ED47

One participant who had presented to a number of EDs for self-harm and suicidal ideation in the past and had a mixture of positive and negative experiences reported that there was generally consistency in the types of questions that were asked but there was a difference in how those questions were asked:

There's very little variance in what people say but it's usually the experience of being asked those questions, it's very different even though they are the same questions...the way they address you and that way they speak to you. ED04

As participants were seen by multiple staff in the ED they had to repeat their experiences many times. While this is a usual experience in an ED, it can be particularly difficult for those recounting deeply personal and distressing mental health experiences:

I was just explaining my story over and over again, it was like words were just coming out of my mouth and they had no meaning to them because I had said it to the triage nurse, to the first doctor and now this doctor. ED01

A number of participants who presented to the ED with self-harm or suicidal ideation had experiences of traumatic events that contributed to their self-harm but this was not explored in the ED:

It was known about all the abuse in my family but no one specifically asked me about my self-injury and how it was related. ED08

Participants reported waiting very long periods of times to be seen only then to have a very brief consultation with unsatisfactory next steps:

The on-call registrar came down and took me into a family room and basically started going through my history and what was going on. And he says 'do you have a plan?' And I said 'yes, I do have a plan'. And I explained what the plan was. And he said basically I am going to prescribe you some medication. And sure if you plan to do it, if you plan to commit suicide sure come in and we'll keep you in. (Laughs) and I'm going, 'that's why I am here! I am here for help!' Yea to be sent home after seven hours, after a five minute conversation with a registrar, that is shocking. ED15

The previous participant and a number of others identified presenting with suicidal ideation but not having actually engaged in self-harm. In some of these cases, participants were unhappy with the next steps advised for them:

There is no help available for you unless you have already done something and that is very much the attitude I have gotten, that feeling that you might do something is not good enough to me. There's an attitude of 'prove to me that you're actually serious and then maybe we'll help you'. ED33

Many participants identified that there was an over-arching focus on the physical issues and that mental health issues were not sufficiently considered. For some people who presented with life-threatening injuries it was obviously important that physical needs were attended to in the first instance; however, once patients were medically stabilised some experienced a lack of focus on the mental health issues that led to self-harm or suicide attempt:

They don't ask about it [self-harm]. They'll ask like 'do you need stitches, or antibiotic cream?'. And that's as far as anyone will go into self-harm with you. Because they know if they open that, they're going to have to sit there for half an hour and listen to you like. ED19

They treat the overdose but they don't treat the mental health behind it. ED10

Once the physical presentation was treated, there appeared to be uncertainty about how to progress with treatment:

I think they just got the medical stuff fixed really and whatever the medical problem was. And then seemed a bit stuck...and your feeling of self-worth which is already why you're there in the first place is even more damaged. Because the very people who want to help you, don't know what to do with you. ED14



There was also a perception that ED staff only considered the physical assessment and treatment as their role so there was a lack of focus on the mental health issues that led to the self-harm or suicidal ideation so underlying problems were not adequately addressed:

In the A&E you got your fluids or whatever. You got everything fixed and it's just like they treat the physical aspects of it and then the emotional aspects they're like 'oh that's not my problem'. So emotionally there was no support whatsoever. ED11

But my experience like they did a very good technical job in the sense that they stitched me up and you know that was fine. And everything was back together except my mind was not better, I was highly stressed and depressed. ED27

In some instances, participants reported being psychologically assessed when they were still very drowsy following treatment (for an overdose) which meant that they were unable to provide the information required for a thorough psychosocial assessment:

I had taken sleeping tablets and drink. I think I shouldn't have been interviewed in that state. I think the answers I gave or the things I talked about didn't reflect correctly what I was thinking. ED05

I wasn't in any physical shape to talk to them and make sense anyway. I know that for sure. ED12

One participant reported presenting to the ED with her counsellor who had been supporting her through her mental health crisis. However, there was resistance from staff in the ED to allow the counsellor to be present for the participant's assessment:

We were called in to talk to two mental health nurses but they were very resistant to [names counsellor] coming in with me. They said 'no you can't do that, you have to come in by yourself'. I was, 'there is no way I'm coming in by myself. There's two of you there's one of me, I'm not coming in by myself. If she's not allowed that's fine, I'm just going to go again'. ED09

While the counsellor was then allowed in, they were not permitted to participate in the assessment:

I was very defensive about what I was going through and very protective of my story. So it was hard to get the whole picture for those nurses. So then the counsellor tried to remind me to say one or two things I suppose and she was told not to interrupt again, not to talk and it was just really patronising. ED09

Many participants highlighted what they believed to be an over-reliance on the use of medication to treat their distress. While the use of medication can be helpful for many, there was a perception that this was the main intervention offered and there was an absence of other psychosocial interventions:

They gave me a prescription for something for a sedative or something to relax me and told me to go to my GP for an antidepressant. But that's not what I think will help me. I have been on medication before and it did nothing for me. But they didn't really listen to that. I wanted some help with the problems I have and how I respond to them. Someone to go to, to get help for that. Not just to be medicated. ED42

There was also a belief by some that psychiatry was not always the most appropriate discipline to be engaged with, and that in the first instance, other disciplines might be more appropriate depending on the causes of the self-harm or suicidal behaviour:

I think it's inappropriate to jump straight in with psychiatry. I think it's more beneficial to have a psychologist or a therapist you know...let's get to the bottom of this? ED08

For a number of participants who had a negative impression of their assessment and treatment there was a sense that it was left up to them to source appropriate help after:

I was just a lucky person that I went out and I got myself better. And I did that. But not all people are like that. It was just like they didn't care in the slightest. ED11

It took me to initiate everything, or my friends. Because after the actual ED presentation there was nothing for days after it. ED02

Amidst the generally negative experience of assessment, there were also some positive experiences. One participant who had multiple negative experiences of her treatment in the ED identified a positive interaction with the triage nurse in the ED on her first presentation:

I was called in to the triage nurse. She was a really lovely, lovely woman. She sat down, talked to me, looked at my cuts and cleaned them. She was the only person who was nice to me in the entire hospital. ED01

Another participant, whose experience in the ED overall had been very positive, detailed how his assessment had been very thorough:

She [the nurse] went through all sorts of things you know. Talked about all the illness I suppose up to then, yeah very good. I was amazed you know. ED48

Many of the positive experiences occurred when the self-harm nurses and sometimes the psychiatric NCHDs undertook the assessment:



...when I saw the self-harm nurse, she's used to doing assessments, she made me very comfortable. She asked me if I wanted to ring anybody to let them know where I was. She got me a cup of tea, like all these little tiny things that makes such a difference....it's the very simple things that make you open up. It's eye contact – and if you have someone who is just constantly filling out [forms], that was one of the things with the self-harm nurse even though she was asking me lots of questions and writing down lots of stuff she still made me feel like she was listening. ED04

They [self-harm nurse and psychiatric registrar] were lovely. They were really nice, they kind of went through the assessment, lots of scales, asking how I feel. But I suppose their main thing was kind of to make sure that I was safe in myself. ED13

The responses of the self-harm nurse helped reassure the person:

They sent down the crisis nurse [self-harm nurse] straight away who was brilliant. Like really, really good. They put me at ease and I suppose in hindsight told me everything I wanted to hear at the time as well. ED17

The ability to ask all the relevant questions but to do so in an unhurried manner that was not off-putting to the person was identified as important:

She [psychiatric NCHD] was very gentle in her approach and her demeanour was lovely. And her ability I suppose to pause and wait and have time was absolutely lovely. She was just able to reassure me. ED32

Another participant reported how the self-harm nurse gave him sufficient time for him to become comfortable with her so he could disclose how he was feeling. This was a very validating experience for him as he presented to the ED feeling like he was wasting time, but ended up feeling that he deserved to be heard and cared for:

At that stage I was just a waste of space and you know I didn't want to go on. So why waste time with me? I thought I was taking up all her [self-harm nurse] time and then she told me that I could have all the time I needed. And she kept coming in and out and talking to me and being real calm as if there was no rush. Now she could have been doing 101 other things but she didn't give that impression. Giving you time just to be yourself. Not pressuring you into saying anything. I felt safe in there. ED48

Another participant reported how the self-harm nurse included their friend in the assessment, asked the person's own opinion about how they could move forward and provided options for what would happen next:

She [self-harm nurse] took me into a room and she had documents and a formal assessment and you know asked me certain questions and documented everything. She was very kind of calm, understanding, let me express things and would ask if she needed. And then she talked to my friend and got his story as well. And then she gave me a choice of you can go in-patient or we can release you with your friend but this is the plan. So there was a written plan that we both signed and got copies of. ED31

For some, the presence of a self-harm nurse also led to a reduction in waiting time in the ED and a more efficient transfer to mental health in-patient care when required:

I know when I saw her [the self-harm nurse] there's an assessment and it's like an hour long. So she'll ask you everything about what's going on, how you are feeling and then she liaises with the psychiatrist on-call so you don't actually have to wait for ages to see the psychiatrist because she can decide whether or not she thinks you need to be admitted and then you can go straight on to the unit. ED04

### 5.3 Discharge and referral

Participants were asked about their experiences of discharge and referral following assessment and treatment in the ED. A number of participants (n=11) were admitted to either a medical unit for treatment of their physical presentation or to a mental health unit for treatment of their mental health problem. However, the vast majority were discharged from ED following assessment and treatment (if required). The discharge and referral experiences were largely poor. A number of participants reported being discharged from the ED without any referral to supporting organisations:

The minute the fluid [IV bag] was out, the nurse just said you can go now. I was never advised counselling. There was no further plan for me. It was like they just kicked me out of the hospital as quick as they could. And my mam was so concerned about how quickly they let me go that she brought me to the doctor a couple of days later. ED11

Experiencing a long wait and the hope that help was available only then to be discharged with no further referral was a source of considerable distress for some participants:

I felt empty, unsupported, alone. I went out and sat in the car. I sat in the car and I just cried. I cried for about an hour because I didn't know where else to go. And I ended up picking up the phone to the Samaritans and talking to them. And I went home to my wife and I told her. She couldn't believe what had happened. ED15





One participant described how having been seen by the triage nurse and waiting for six or seven hours while alone and distressed decided to leave and go home. The response to her decision was not reassuring for the participant:

She just moved her hand [waves dismissively] and said ok, go. I asked her how long more I needed to wait to see the doctor and she said maybe the next couple of hours, maybe tomorrow morning. So I left. She didn't ask if I had someone at home to help, she didn't tell me where to go. I mean I don't know how I survived. I don't even remember my way home – I just walked automatically. ED38

On a subsequent presentation to another ED, this participant again had a poor experience of discharge and follow-up:

I was discharged from the ED and she [the doctor] promised me that someone would call me next morning but they didn't. So then I was thinking that it's the weekend and everyone is busy and maybe the doctor isn't working and she's off a few days from her shift. So I was waiting again all week until the next Monday. Nobody called me back for the next 10 days. Then my husband had to ring. ED38

Another participant presented feeling suicidal after a period of time sitting on a river bank considering suicide. She had a referral letter from her GP to whom she had presented a few days previously. However, she felt very unsupported in her discharge from the ED. Following a long wait to see the psychiatrist, she was discharged quickly following what she believed to be inadequate intervention and a referral to the mental health services which came 3 weeks later:

I told her I couldn't see any point in going on so she gave me the name of an app on your phone where you can name your feelings, which really just seemed ridiculous and then she prescribed quetiapine, asked me if I was driving myself. I said I was and she said 'well can you wait until you get home until you take it in case you have an accident on the way' and that was it. She discharged me. So I drove back to the river to be honest. ED33

The majority of participants in this study were attending a mental health service for on-going treatment of their mental health difficulties. Most participants reported that once their physical health needs were attended to, they were then discharged back to their mental health team for follow-up. However, many participants expressed unease about the time period between discharge from the ED and follow-up from their mental health team. There was also a sense that if a person was attending a mental health service they were perceived by the ED staff to be 'covered' in terms of follow up:

When they know you are already attending a mental health service they think 'oh that's grand, you can go back to see them then'. It's like it's something for them to fall back on, to cover them nearly. ED40

Family members were also in some instances left unsupported following the discharge of the person from the ED. This participant describes how having been discharged from the ED following treatment of an overdose and referred back to her mental health team, her husband was left to care for her in the immediate aftermath with no information about how best to help:

My husband didn't sleep a wink at all. He didn't know what to do. Like he told me they didn't tell him what to do or anything. He felt very alone, no support whatsoever. ED12

The impact of a person's suicide attempt and continued suicidality on family members and the fact that the 'burden' of care was often left to family in the ED and immediately after was clearly identified:

It was very traumatic, extremely traumatic for my family members to be part of that...when I was in the psych unit I was put on special [one-to-one nursing observation] but they don't have that facility down in the A&E...so it's kind of left to your family. ED34

Another participant presented to the ED following an overdose accompanied by her mother. However, her mother who was frightened and scared by the experience was not engaged with:

They didn't really speak to her and she was so distraught I don't think she engaged with anybody really. ED14

This participant also had experience of accompanying her father who presented to the same ED sometime later with physical problems. However, in this instance, as his accompanying relative, she was kept informed of his treatment and treated very kindly and it was a juxtaposition of her own presentation to the same ED previously:

He was so well looked after. And really kind, everybody was so kind to him and to me with him. But not when it was me with my mother in reverse roles. ED14

There were also some positive experiences of discharge and onward referral from the ED. One participant who had many previous negative experiences in the ED highlighted more recent positive experiences:

The day after I was called by a mental health nurse – she was very lovely, just kind of talked to me, they said 'now you have been discharged what is your plan, have you got it?' And she just talked me through some kind of ways to deal with overwhelming feelings. It was a nice follow-up and I wasn't expecting it. Because the next day you're still very distressed but when you have someone calling you're like ok – they haven't forgotten. ED05

Another participant identified how a plan for discharge and follow-up was made for him in the ED which was reassuring for him when he was experiencing significant distress:



The mental health nurse in the hospital worked out a plan to help me. She had it all worked out. She got me to contact my nephew and she contacted my GP so when I went to him I didn't have to explain it to him as he knew everything. The nurse that I'd been dealing with all night had spoken to him on the phone, right, that's amazing. She also contacted [names mental health facility] with my permission and I was no sooner back from the doctors that evening when they called me. ED48

Demonstrating that there is variability across different EDs, one participant detailed a particularly negative discharge experience in one hospital only to be followed up with a positive discharge experience the next time she presented to a different ED:

When I went home they [the self-harm nurse] were calling every week for the next 2, 3, 4 weeks just to make sure I was doing ok. Asked if I needed anything or stuff like that. That felt good, a lot better than my [names ED] experience. It was reassuring because it didn't feel like I was just being thrown out, you know. ED31

The importance of including a friend or family member in the discharge process (with the participant's permission) was also identified:

Discharge from the ED was done compassionately with my dad present to ensure that everything was understood and would be followed. A phone call was made after by a mental health nurse to check how I was. ED35

## Chapter 6: The Emergency Department Environment

### 6.1 Introduction

In relation to the environment of the ED department three subthemes emerged:

- Waiting times
- Physical structure of the environment
- Nature of ED patients

### 6.2 Waiting times

For the past number of years, Emergency Departments in Ireland have become synonymous with overcrowding and long waits for treatment for most patients presenting without an acute emergency and this was no different for participants presenting with self-harm and suicidal ideation. There was some variation in waiting times but many participants mentioned waiting for significantly long periods of time to be seen by a mental health specialist. In many situations people were waiting up to 6 hours but for others it was considerably longer:

So they kind of brought me in a trolley, left me in a corridor but I actually didn't get seen to for I'd say 4 hours maybe. Was just told to have a sleep basically. I had seen a nurse and she'd done my bloods and my blood pressure, just in the triage. Which generally is quite quick. But in terms of assessment yeah it was minimum 4 hours. ED05

I waited for hours... It's a really horrible experience ... I was sitting on a chair ... I think on a Saturday afternoon like I took the overdose and I went in about 3pm and I didn't see the psychiatrist until half one in the morning. ED04

Most participants anticipated a long wait in the Emergency Department and were resigned to the fact that this was an expected occurrence in the ED:

I was triaged first but I was waiting about 3 or 4 hours at least and I saw the doctor then and the nurse. It was early in the morning, it was about 2 o'clock in the morning. I have nothing negative to say about my treatment... I was waiting about, from about half 9 till about 3 o'clock in the morning... you just have to wait and be seen. ED39

Rather than feeling they had arrived in a safe space, waiting in over-crowded, noisy waiting rooms appeared to heighten people's anxiety and emotional distress:

It's not a place for people who are after you know trying suicide, or who feel suicidal or anything. Because as everyone knows like it's the most stressful place in the world anyway. ED17



It wasn't nice...Because you're so distressed and you're so emotionally unstable. Just being in an environment like that it just does not help at all, at all. ....A hospital environment is horrible and when you're emotionally distressed, being in that environment is really adding to it. ED11

I was expecting a delay waiting in the Emergency Department, but we were given a time of three hours, and as it went over this time, I was completely frustrated and uptight... There was a lot of very sick and elderly people who were waiting over 12 hours. It was extremely busy and I was extremely stressed about the waiting. ED35

Participants described overwhelming sensory experiences with distressing noise, sights and smells which again served to heighten distress:

Everything sensory was completely different. The lights, different smells...it's completely overwhelming to the point where you don't know what to do. Like the noise, depending on where you are you could have like someone screaming in pain or someone shouting. There was a fight that broke out in the Emergency Department waiting area so the security guards were running everywhere. ED05

The long waiting times when experiencing mental distress also contributed to participants feeling self-conscious about their own presentation:

In my body I could see the anxiety in my body, you get to a point where you feel like everyone is looking at you, they all know that you don't have an ailment so to speak. Like you're not bleeding from somewhere or you're not limping or you know and I was like, like I just feel like I'm crazy sitting here. I think it [stress] very much builds up and builds up, the longer that I was sitting there. ED32

And they just made me wait and wait and wait and wait ... I got a bit paranoid because I was thinking they are probably looking at me on the camera and you know should I get out, it kind of got into that weird funny situation but it was the waiting. ED44

The long wait time also meant that by the time many participants were seen they were too exhausted to engage meaningfully in an assessment:

I saw the psychiatrist at 3am [14 hours after presentation] but at that stage I was just saying the right thing to go because I was just so tired. I'd spent the whole day crying and I was physically exhausted and I just didn't want to talk anymore, I just wanted to go home. ED12

In addition to heightening distress the waiting times increased peoples' desire to leave the hospital:

It's very much like you just want to go home. But you know if you go home you won't get the help and going home may also be the worst possible case. But it's like these 2 conflicting. ED05

We [participant and sibling] were waiting in the waiting room for hours, I mean hours, to the point where I was like I think we just need to leave. And I mean hours. ED32

For those who were unaccompanied while in the ED, the long waiting time was particularly difficult and increased their desire to leave:

Sitting there on my own for that whole time, it felt very lonely and I started thinking I should not be there, what can they do for me when all this is going on. Everyone else seemed to have someone with them so that made me feel even worse. I was just going to leave when they called me. ED20

In many situations the only reason people stayed was the person accompanying them convinced them to stay or staff had asked the security personnel not to let them leave:

He [family member] was like no you just need to wait, you need to be seen. And I think it got to the point where he was holding my hand at one stage and he was like just concentrate on staying and I was like getting very agitated. ED32

I waited until, like it was 3 o'clock in the morning when I was seen. And if my husband had not been there I would have walked out. ...The fact that my husband was there, he stopped me obviously. But if I would have been on my own I could have easily walked out, taken my car and gone home and tried to kill myself. ED12

Everyone was just so ill, they were really, really ill and I just wanted to leave. But they had the security, obviously the triage nurse told the security not to let me leave. So any time I was even going out for a cigarette like the security would be watching me like a hawk. ED01

On one occasion, the nurse saw the person about to leave and quickly engaged with them. In an effort to respond to the person's distress, the nurse relocated the person to the only calm and quiet space available, which was a cupboard:

I waited for four hours. I was getting increasingly way more agitated as time went on. So I decided I'm just gonna leave but that nurse saw me go to leave and she called me back... she was so lovely, so kind and I explained to her I just couldn't sit in the waiting room any more, it was so noisy and it was just not helping and she said 'I'll find somewhere quiet for you to wait, just, please just give me ten minutes, I will find somewhere for you to wait'. The only place she could find was a store cupboard so it was essentially just two foot by two foot with lots of shelves up and down each wall. So she put a chair or a stool in there and she said 'look you can wait here, it won't be as noisy', and she went, she came back after about twenty minutes with magazines she got from her own locker and was like you know, try and flick through them. So she was I have to say just a lovely human being. It did help in that it was quieter. But there were, there was staff constantly in and out getting things. ED33



### 6.3 Physical structure of the environment

The physical environment of the ED was commented on by a number of participants. There appeared to significant variability in the type of facilities available to people experiencing mental distress. A small minority spoke of being interviewed in a private room, which enabled them to disclose information without worrying about it being overheard:

They've a separate room for interviewing the patient ... at least they made some provision. So that was positive that you could speak in confidence and you know no one else is listening or you know... having a room there in the ED is very important because you feel safe and you feel you can talk to the doctor in confidence and you have no one else listening. You're not just telling the doctor in the middle of the corridor like and everyone listening. ED39

When I went to [names ED department] they had a room that was specifically for the assessments. Not like a cubicle like sitting on a bed where everyone can hear what you are saying. It was a room behind a closed door. That really made a huge difference. Because I didn't feel that I was in a crowded space talking about really personal things where everyone could overhear what I was saying. ED04

For some, the availability of a quiet room to be interviewed and assessed in was the difference between disclosing suicidal thoughts and not:

What was important I think here was the room. Just an ordinary room, a side room. Like I couldn't have talked to her [self-harm nurse] outside, you know. I'd just be sitting there in a chair and I wouldn't have said anything to anyone. But after an hour in that room, you felt you weren't in danger you know...it was like another world because when you opened the door it was chaos going on outside. ED48

In contrast the vast majority spoke about the lack of privacy, because they were being interviewed and assessed in an environment where their personal information could be overheard, or there were people coming in and out of the space they were allocated. This lack of privacy resulted in some participants being reluctant to discuss and disclose their distress:

There's the privacy of it as well. I mean, if you break your leg, it's not really a personal, private, upsetting nature, you know. Okay it is to a point, but you know not really. But if you're going in there and you want to die, ...you're at your rawest of your raw at that point. ED09

And then I was brought into the triage room which ... it was like inside the door, so like its right next to reception... you could hear things going on the whole time. And I was just like, this is so close to everyone, like this is a really personal emotive issue. I was pretty low at that time. So I wasn't going to react. But my mum was so like upset. ED18



And in [names hospital] even when you have to see your registrar or your psychiatric team, there's no room for your psychiatric team. So there's a room that everybody seems to use... You're going into this room with a registrar but it's really your room. People pop in, 'oh sorry' and then go back out again. But there's nowhere for you to go to talk about how you feel, there's nowhere for you to go to talk to feel comfortable. ED10

In other situations, meeting people they knew in the waiting area who were asking them questions in relation to the reasons they were attending the ED, exacerbated their sense that the environment did not cater to their need for privacy:

So then I was sent back out to the waiting room. It was packed, I just remember crying and I actually saw a few people I knew and they were like why are you here? And I was like ah I've a really bad stomach. It was packed full of people. ED01

Like the people I would've sat beside would've you know, would've been friendly. And everybody trying to just pass the twelve hours or whatever. and I couldn't tell them [why I was attending], so I was making up ridiculous [answers] ... anything but tell them why I was ill, no way I would've told them. ED14

Others spoke of being asked to sit and wait in a type of observation room that was surrounded by glass and positioned in the middle of the ED. While participants appreciated that staff were concerned for their safety the 'fishbowl' environment once again exacerbated their shame and sense of loss of dignity and contributed to the perception that they were different from other patients:

She [nurse] brought me into this little room which was in the middle of the whole department. I know okay there's the safety issue and you have to keep an eye on things...but it was so humiliating sitting in a little box in the middle of the Emergency Department, it was glass. Having that room in the middle of the ED it's horrible. Nobody puts themselves in the patient's position before they built that. ED02

I was brought into a glass room in the middle of like the back ER so to speak, it was like a meeting room ... but it was glass. And that's where I had to tell her how I was feeling in a glass room. I don't think, my anxiety has never been so high in my life. And I asked for another room but there was no other room available. ED32

In some instances, participants were left in an environment with a sharps container, which they deemed unsafe as it increased their thoughts of self-harm:

And I remember sitting in that room and there was a curtain and there was a box full of sharps and there was, I literally sat in the room and thought about I'd say 50 different ways I could have killed myself in that room. I was like don't do it. Don't do it. And he [ED doctor] would pop his head in every hour, I was there in that room on my own for 3 and a half hours. ED01

You're in A&E for a long period of time so you're very much at risk. You're not monitored...and obviously there's syringes and there's all sorts of dangerous stuff around. I was lucky because I had my family to keep an eye on me. ED34



## 6.4 Nature of the Emergency Department patients

Participants also commented on the inappropriateness of the ED department for people experiencing significant emotional distress, especially in the context of being ‘mixed in’ with people with physical health issues. Watching both the patients and the hurriedness of the staff appeared to reinforce participants feeling that they were ‘taking up a trolley’, not worthy of having medical or nursing time spent on them or that their health needs were not really a priority.

I think that A&E isn’t the place for somebody when they’re going through that [emotional distress and self-harm]. First of all that is stressful for somebody who’s going through an acute mental health issue. But also ...there’s somebody in there who’s broken their leg. There’s somebody in there who’s you know coughing up blood. Just I think those things just need to be separate...But the way that it is now, they’re [medical and nursing staff] just trying to turn over all the patients as quick as possible. You’re taking up a trolley. And we need to get that person in with the bleeding leg, and you’re just here crying about something. I would never go to A&E again, no way. Even the thought of, even just the memory of all of that is horrible. ED09

I felt like I shouldn’t have been there. I was taking up a chair nearly. The nurses would’ve been compassionate but just too busy. You know they had to look after someone else who was sick [physical]. I felt like an inconvenience really, like what are we going to do with this one. There isn’t really anything wrong with her. ...when you’re sitting there [waiting area] and you can see they’re struggling it’s so busy. And there’s machines going off and there’s ambulances arriving. ED 14

Other people are actually sick and you don’t think you’re sick. And you’re like I shouldn’t be here, I don’t need to be here. Why the hell am I here with all these people, it ruminates in your mind constantly. And the longer you’re there the more you go over and over and over that in your mind. And I think that adds to the fact that you just want to get up and walk out. ED32

Some participants who presented to the ED without having actually self-harmed spoke about the common advice given about presenting to the ED and their difficulty with this advice:

The ED is always given to you as the go-to service, like if you have any intention of self-harm or suicide you’re told to just go there. But you feel you’re going to be sitting in the waiting area for a couple of hours just to talk to someone. It’s not the right place for this but it’s where we are told to go. ED05

A&E itself I think is about the medical. It’s not really about the mental. I’ve always been told to go to A&E, go to A&E, go to A&E, but it’s not really a place to go. I wouldn’t feel comfortable if I was feeling suicidal to go to A&E because what are they going to do? They’re not going to do anything for you. ED10

## Chapter 7: Negative Experiences in the Emergency Department

### 7.1 Introduction

Half of the participants (n=25) in this study had an overall negative experience in the ED while 18 had mixed experiences. This theme describes the negative experiences and interactions the participants had which focus on three main areas:

- Othering
- Uncaring and unsupportive interactions
- Lack of knowledge and understanding about self-harm and suicidal behaviour.

The impact of all these negative interactions is discussed in Chapter 8.

### 7.2 Othering

Many participants reported that they were made to feel different from other patients who presented to the ED with physical problems. Presenting with a mental health difficulty meant that they were 'othered'; or classed as 'different' from other people presenting. There was a sense of being assigned a mental health label and set aside from other patients:

The first time I went to [names hospital] they didn't have a self-harm nurse at that time or anything like that. And I remember going into triage and the Emergency Department was very busy at the time and the nurse gave me a chair to sit on. She sat me in the middle of the A&E and she just very bluntly said to another nurse – watch her she's suicidal. And I remember just feeling like, like so small and so tiny they way she made me feel about myself. ED04

One participant describes how she felt following an unhelpful comment by a consultant in a private hospital she attended after a serious self-harm wound re-opened:

So my GP rang [names hospital] and talked to the consultant there and he said send her up. So when he came into the room to me he said to me 'we wouldn't normally treat people like you'. In that tone of voice...I felt like I was abnormal and this was all of my fault. ED27

Findings relating to the physical environment of the ED have been discussed in the previous chapter and one of the issues identified was the custom in some EDs to place people who present with self-harm or suicidal behaviour in some type of observation section. While the rationale behind this is to keep people physically safe, it often served to set people aside from others presenting with physical problems and often meant that they were classified as 'psych patients':



I was put in this observation room. This little fishbowl and I felt like a performing animal. As soon as I went there I knew it was for ‘psych assessments’. They had security sitting right outside it and I could hear the tea ladies standing outside debating whether they can give you a knife with your sandwich. ED36

Another participant recounts how her experience of being assessed in a ‘special’ room cast her as ‘different’ from other patients presenting and felt stigmatised by the process:

I remember the first thing I noticed was all the chairs were nailed to the floor. Which straight away made me uncomfortable; because I was like what do they think of people like me if they think they need to nail the furniture to the floor? ED09

Participants reported how they were made to feel that they were less deserving of care than other patients who were presenting with physical problems. This was expressed to them in a number of ways. In some cases it was put to them that their receiving attention meant that other patients were not:

She [psychiatrist] said that she knew I’d been waiting a long time but there was an eighty-two year old woman sitting waiting in the waiting room who she said I jumped the queue in front of, so to be honest that just made me feel worse than shit. ED33

She [the nurse] told me I was wasting their time; they could help real people instead of childish behaviours like me. ED19

Another participant overheard nurses commenting on her care:

The nurses made me feel like I was such a nuisance, like you know you are taking up a resus [resuscitation] bay. I could hear this. I know they weren’t saying this to me but I could hear it. And it was like, I was the worst thing ever to come into the department. ED02

Many participants spoke about how ED staff compared their presentation for self-harm or suicidal behaviour to others who presented with physical problems. The comments generally focused on how people who self-harm have a choice in what led to their presentation at the ED, whereas people with physical presentations did not. While in some cases it seemed that these comments may have been meant to encourage the person to feel more positive about their own situation, it generally had a very negative impact on the participants:

I’ve had it said to me ‘you’re here in A&E, resus [resuscitation] is across the way and there are people fighting for their lives and you’re here trying to finish yours’. It makes you feel rubbish. ED36

There was also a sense of sometimes being treated like a ‘bold child’ at times. One participant who was in her 50s and overall had a very positive experience of the ED reported how this made her feel:

You feel bad enough already, you don't need to be made feel worse. In A&E there was one nurse who was kind of 'you fucking ejit for doing that', you're a bold girl in other words. She made me feel like a bold child, but I already felt like that myself so didn't need to be told it. ED10

Another participant who had presented to the ED was placed in a position where she could hear the assessment of another woman who was brought in by 2 Guards following a suicide attempt. Again, the language used was reminiscent of that which would be used with a child:

The person was brought into triage after me so I could hear and see everything...the entire time she was there the nurse and the guard just...they were saying 'you won't be doing that again now will you? Now you'll behave for the nurse won't you?' You know just treating her like a child and she was older than me. ED09

Participants reported that their problems were sometimes minimised by staff in the ED. One participant who presented after an overdose explains how this was portrayed to her:

And eventually she [psychiatrist] came down, she spoke to me and she told me hospital wasn't for people like me who couldn't cope with life. It made me feel awful because I was in a desperate, desperate state. I just wanted to die...and I thought that was a ridiculous thing to tell someone who was in a state like me, to tell me hospital wasn't for someone like me. Was I meant to go home and die? That's how I saw it. ED03

Some participants reported that ED staff appeared to question why they were there when they had no physical injuries. However, as one participant succinctly described her presentation in a suicidal crisis was the equivalent to a serious physical injury:

I understand that there's people [presenting] with physical injuries and they are checking to see who is the worst and who needs help straightaway. But when somebody is literally suicidal...that's me coming in with arteries open. But it's a mental artery not a physical one. You can't see it on the outside. ED44

The often non-visible nature of the mental distress of participants who presented to the ED meant that they were automatically set aside as different from those who were presenting with obvious physical injuries.

I could see people who were really sick you know. But nobody could see how sick I was. ED14

It's like just because I am not bleeding, or have a broken leg or something that I don't have anything wrong with me. But I do. I didn't come here for nothing. I needed help too. Just because it's harder to see doesn't mean I am not hurt. ED43



A number of participants reported the belief that if they presented with a physical illness as opposed to presenting with self-harm or suicidal behaviour they would not be treated in a negative manner. One participant who identified a number of unhelpful and unsupportive interactions when she presented following serious suicide attempts and now advocates for improvements in mental health provision reports:

If it was a physical illness and they literally gave you the opposite type of care to what you needed, there'd be all sorts of lawsuits and all sorts of uproar. But because it's a mental health problem people aren't speaking out about their experiences. To me, the ED is giving you the opposite medicine of what you need, but people aren't talking about it because they are too ashamed. ED34

As identified in the previous chapter, another participant who was able to compare her presentation to the ED in significant mental distress to a subsequent time when she accompanied her father to the same ED for treatment of his physical problems described the differences in the attitudes she encountered:

I had to bring my dad there a while ago and even being back in that place was just so awful. Remembering what it was like when I was there. My dad was very well looked after, he was physically sick and I actually thought do you know that he's being very well looked after. Nobody's questioning why he's there...but I had put myself in there; I made a choice that landed me in there. And when my dad was there it wasn't his fault, and it wasn't a choice. ED14.

There were a number of participants who reported that they were diagnosed with a Borderline Personality Disorder (BPD), more recently known as Emotionally Unstable Personality Disorder (EUPD). This diagnosis seemed to at times overshadow the person presenting and their needs at that time. Some participants reported how this influenced how they were treated in the ED:

There was one nurse who was really nice and she kind of made it a bit easier for me, but the psychiatrist was horrible and I think..hmmm...my diagnosis at the time was a borderline personality disorder. And I'm sure if you speak to anyone who has that diagnosis they will tell you that it's a horrible diagnosis and people treat you very badly when you have it. People who have that diagnosis are deemed to be difficult to work with and like a lot of times when they present to A&E and the professionals know that they have that diagnosis they often just think it's attention-seeking. ED04

It's like, you hear them behind the curtain like (whispers) 'personality disorder', you know, 'borderline – she'll be fine, just an attention-seeking borderline'. ED36

In addition, it was suggested that there was a lack of understanding about the diagnosis:

He [doctor-on-call] did not understand the term EUPD and made me feel like I was making up the diagnosis. ED30

### 7.3 Uncaring/unsupportive interactions

For many participants, the negative experiences they had in the ED were centred on the sometimes uncaring and unsupportive interactions of some ED staff with whom they engaged. In section 7.2 it was reported that a number of participants identified how staff sometimes commented that their care for ‘self-inflicted’ wounds meant that care for others presenting with ‘real physical problems’ was impacted. By extension then, many participants reported that they were made to feel like a nuisance when they presented to the ED:

I got to see the psych person on-call and you often feel like you are a nuisance. They seem to be very busy and I always felt that I’ve been inconveniencing them. ED04

In their eyes, you’re just someone who’s taking up a bed and who’s in the way. And they just want you out, do you know what I mean? ED11

Participants reported negative interpersonal interactions with some staff in the ED which impacted on them:

She [ED nurse] was treating me like I was a waste of her time. As if she didn’t have time to be dealing with me. And just the way she referred to me to other nurses was really degrading. ED04

Participants spoke of being dismissed:

They were very dismissive...the actual people who were supposed to be supporting me or making decisions about if I’m staying or going and that kind of stuff, they were very dismissive and they just didn’t want to listen to my side of the story. ED31

I was rubbished really. I wasn’t tenderly treated so to speak. I wasn’t kind of guided. ED08

Many participants discussed the apparently negative attitudes that some ED staff they were interacting with had towards them. In some cases, the negative attitudes were implied in how staff interacted with them:

...her [ED nurse] whole attitude – she didn’t even have to say anything for me to know that she wasn’t happy with me. I was a problem. ED02

She [ED nurse] said something like ‘was it an accident?’ and I said ‘no’. And I just remember her face being so disgusted. I felt judged. I felt actually judged by the nurse. And just yea just in general the nurses and doctors were not nice at all. ED11

In other cases, the negative attitude was explicit – the participant was on the receiving end of negative comments:

She asked ‘why are you doing this? You are so young, is this all attention-seeking?’. They actually said that to me. ED01





This theme of being ‘attention-seeking’ was brought up by a number of participants in a range of different contexts. In some situations such as that highlighted above it was suggested directly to participants that their behaviour was attention-seeking. In other situations, this was conveyed to their family members:

While I was asleep both my sister and my mother were there. And the nurse called them over, they were obviously in bits and she said ‘look at her arms’. My arms were slit upwards. And she said to my mum ‘they’re superficial cuts. She’s doing this for attention’. ED34.

In some cases, it was apparent that some of the comments by ED staff that were perceived as negative may have ultimately been well-meaning but this was not how they were received immediately following a suicide attempt:

She [ED nurse] said ‘you have children, don’t you?’ At this stage I was throwing up as I had overdosed. I was coming to terms with the fact that my attempt hadn’t been successful. And she said ‘your children will have a one in three chance of following you once you’ve died by suicide’. She said ‘by doing this, this is the chance you’re giving them because they now have one in three chances of following in your footsteps.’ That was so hard to hear. Because I understand her message and at another point in time I might have been able to hear that news in a constructive way. But I was at a stage where I hated everything about myself. I was so low; I couldn’t have hated myself worse. ED34

Another participant commented how her physical appearance was commented upon and this was something that impacted her:

He [ED doctor] said ‘what is a good looking girl like you doing this for, sure you have everything going for you...you’re throwing away all your good looks and throwing away your life’. And those comments really really bothered me. ED09

As another participant succinctly suggested:

They are trying to be inspiring, but yeah it goes the other way. ED36

Participants acknowledged the busyness of the ED environment but still maintained that this did not merit their negative treatment:

Although I understand and respect that the ED is chaotic and that staff are run off their feet – I felt as though I was only a number. The doctor-on-call was very rude and did not respect my privacy. ED30

There was also the belief that they were not being taken seriously:

You’re just like a number or something to them, they are just going through their questionnaire. ED07

I wasn't being taken seriously. I was just another person, people didn't care. ED44

Nobody really took me seriously. And nobody reassured me to say 'oh I hear you, at least we're trying to get you some kind of support'. It never happened. ED12

They didn't have time to be dealing with something that maybe wasn't straightforward. And that on the list of patients [with physical presentations] I was probably at the bottom. ED14

Most participants who presented with self-harm injuries which required attention reported that their medical injuries were treated and managed very well. However, with a small number of participants, this was not the case:

When they were stitching me it was like...you know, oh god it was just horrible. It was just done so rough and kind of like, well you did this on yourself. ED02

I remember waking up [in the ED] and I was handcuffed to my bed with two Guards beside me. And they had handcuffs on my wrist where I had just self-harmed. It wasn't deep or anything but it was really painful. ED19

A number of participants reported feeling intimidated by the threatened arrival of Gardaí if they were to leave the ED. One participant who presented to the ED feeling acutely suicidal was told following assessment that if she left the guards would be called. In a busy ED with limited time to spend with individual people this may have been meant as a way to encourage the person to wait for treatment and referral, however, it was perceived in a very negative manner:

That kind of got me a bit. My freedom being taken. The way then all of a sudden that if I was going to go that the guards were going to come out and detain me. That was just so negative. ED44

However, for this participant it was the threat of the Gardaí being called that made her stay in the ED and from where she was subsequently admitted to the mental health services for treatment:

I'm not sure what made me stay in the end, it was probably the threats that were made, that it was going to get very nasty if the guards had to come out and detain me, and the whole hullabaloo around it. I didn't want that. ED44

The negative attitudes from some staff in the ED had a clear impact on participants who just needed some care and reassurance:

All I wanted that night was someone to say that I will be ok, that we'll get you help, we'll sort this out. It will be fine. But instead of that I was just met with such hostility like nobody cared. Nobody wanted to know. ED02



## 7.4 Lack of understanding of self-harm and suicidal behaviour

Although the participants acknowledged and appreciated that the Emergency Department was comprised primarily of people who are physically ill; they were shocked and frustrated with the lack of understanding and compassion about mental health and in particular self-harm and suicidal behaviour displayed by many of the Emergency Department staff. Some participants felt anger and frustration when they felt that the staff did not have the training to understand their feelings and situation or treat them professionally:

And he said the exact same thing, you know, why are you here, you know there's really sick people out there and you aren't sick. And I turned around to him and I said what do you mean, he said well other than you crying you don't look sick. I was like well people with cancer don't look sick either, so are you going to say that to a person with cancer. And he was like well no because they have a diagnosis and I was like well so do I, I said it's just a mental illness. I was like am I just a menace. (ED04)

He first of all asked me why I'm here. I told him, well my friend told him and he looked at me and he said 'you are really young, you don't have a mental illness'. I remember looking at him going, 'well I don't think age really has much to do with it'. He was like 'well why would you do this to yourself, you are in college, you have so much going for you?' (ED09)

Some of the unhelpful comments reported on in the previous section appeared at times to be as a result of a lack of understanding of mental health. However, the impact of these comments was significant as reported by one participant who was questioned as to why she self-harmed when she was 'so young':

The whole thing about being young, I just think it was a lack of understanding. I think there are people in certain jobs who just don't understand mental health, they haven't a notion. So they have no idea of how bad it is in those moments, and what leads someone to actually take their life. It's the worst place you will ever be. It's the worst place I've ever been. ED03

Many participants, particularly those who reported having self-harmed with no/little suicidal intent, talked about a lack of understanding about the function of self-harm and the purpose it can serve for people:

He [doctor] so doesn't get anything. He said 'but self-harm is not going to fix anything' and I'm like 'yeah but it's helping now'. ED19

One participant reported how her overdoses which were not driven by suicidal intent but rather served other functions were never understood by ED staff who seemed to always equate an overdose with a suicide attempt despite the participant saying otherwise:

They are very caught up in the whole concept of suicide you know. Like if you took paracetamol, you're killing yourself you know, they're very much caught in that concept. I think if I was cutting it would be a different thing but no, they always say 'I see you presented here three times with attempted suicide last year' and I always say 'no I didn't. I presented three times alright but no, I didn't want to kill myself.' It's not about that for me. ED36

Conversely, other participants reported how their self-harm which had suicidal intent was also not understood:

I know what my intention was that day. My intention was to end my life. But she [ED doctor] made all sorts of assumptions about what was actually going on for me. ED34

Another participant who had taken an overdose of her antidepressant believed that she was not treated with sufficient seriousness as the overdose was medically not dangerous – a fact she was told after her presentation. However, she had not been aware of this at the time of the overdose. This highlights the importance of not always judging the seriousness of a self-harm act by the medical seriousness of the act itself:

They told me that those antidepressants actually can't kill you if you overdose on them. But I was like, 'oh what an idiot, how did I not check' do you know what I mean? ED 18

However the importance of having someone who understands self-harm engage with participants was clearly identified:

So I guess if you have somebody who knows about the difficulties with self-harm and how somebody might feel about themselves for self-harming it makes such a huge difference. ED04

It was acknowledged that most ED staff who see participants prior to being assessed by a mental health professional (if they do get to see one) may not have a sufficient understanding of mental health generally and self-harm/suicidal behaviour in particular:

I guess it's very obvious when you are speaking to a nurse at the triage or you are speaking to a maybe a doctor on call that they don't really have a clue about mental health. ED04

It was recognised that these staff are experts in a wide range of physical illnesses but that knowledge and skills relating to mental health was deficient:

Sometimes I wish I did have a physical illness because it's understood more. But when you go into A&E with a mental illness, there's no understanding and I don't know if there's training. ED10

The A&E staff do need to be a bit more aware. They are dealing with a huge amount of different illness and stuff. And I just feel myself that they don't have the necessary skills and the necessary understanding to be able to adequately deal with people that are in difficulty with their mental health. And struggling with suicidal thoughts or behaviours, you know. ED34



While there was an expectation that mental health may not be well understood by the wider public, there was an anticipation that it would be better understood by healthcare professionals which wasn't always the case:

I feel there's a lack of understanding. And you don't expect it from a nurse because you believe nurses should be more aware. I do expect it from other people and I get it from family members sometimes but I don't expect it from nurses. ED10

This led to a call from participants for some training in mental health for those non-mental health staff working with people who are suicidal or have engaged in self-harm:

You don't necessarily expect them to be experts [in mental health] like that's not their job, but they do need to know the basics. And what to say and what not to say. Particularly what not to say. ED28

This focus on 'what not to say' was echoed by many participants who highlighted the need for ED staff to be mindful of the language they used when discussing self-harm injuries and the impact this language might have:

Sometimes the nurses can say 'oh it's [the wound] superficial', and while that's just their terminology, it's hard to understand. Did I not go deep enough to warrant care? Did I not do enough to warrant attention? When you think of the idea of superficial you don't associate good things with it. Superficial is something that is, you know in a sense shallow, not a lot to it. ED05.

The psychiatrist said I had a strong will to live which in a way made me feel insulted because I felt as though I was dying in front of him and all I wanted to do was take my own life. I felt as though nothing could save me, and so to hear those words from him made me feel as though he didn't quite understand. ED30

This apparent deficit in mental health education in non-mental health staff was reported by a number of participants, including those with a professional background in healthcare provision:

I think because again the nursing background, I've seen where we don't have enough training in undergraduate to start with. Like I think we had a week of lectures on mental health and they didn't even touch the surface. You still don't know how to speak to patients to try and understand what's going on. ED02

I deal with people with mental health problems nearly every day. It's part of my job, but we don't get enough training in how to do it. There's always some other training that's more important. And that's probably the same for people working in A&E. ED21

In the previous section, it was identified that for some participants, they were labelled as being ‘attention-seeking’, however, participants reported the need for ED staff to better understand that their self-harm is not attention seeking:

I mean the weird thing is like there’s a negative stereotype about you know when you’re in that state. That you’re attention-seeking. But like at the end of the day with the majority of people it’s the exact opposite. Because you are so desperate, because all you want is to not take up people’s time, energy, attention. ED16.

Participants also identified that as mental distress is something much less visible than physical distress, it requires assessment from someone who understands how to elicit key information:

When I’m in crisis I’m not the kind of person in who it looks visible. Like I don’t be crying, I don’t be doing anything like that. Now I realise that it’s often left me in a situation where because I don’t appear distressed they feel I might not be distressed enough to need admission to a hospital. ED04

Similarly, another participant also explained how her physical appearance can be deceiving and can contribute to a masking of the mental distress that she is experiencing:

Some people are really good at hiding things and I am one of them. I am very high functioning regardless of what is going on. I’ll still appear well, like I’ll still put on my make-up and put up my hair even if under all of that I have black eyes and pale skin. And it’s all just hidden so maybe it’s because of that they [ED staff] don’t take me seriously. ED09

Highlighting the importance of having the requisite skills and knowledge of suicidal behaviour to carry out a thorough psychosocial assessment, a number of participants reported how they hid their own suicidal thoughts when presenting for treatment and how it requires skilled probing to uncover suicidal behaviour:

And assessing us, just I suppose they need to keep in mind that we lie. I mean I lied to get my hands on whatever was closest to me. While I was in the A&E department I wasn’t ok...and when you’re suicidal you tell a lot of lies and you cover up. Because you just want that five minutes to be on your own and to get whatever it is you need to get your hands on to finish what you started...so you’re very much at risk...and that’s where I feel there is a huge lack of understanding. ED 34

Participants spoke about the sometimes impulsive nature of their self-harm thoughts and behaviour and how this requires extra vigilance and understanding. Impulsivity can make it more difficult to assess self-harm and suicidal thoughts, and knowledge of this is required when working with service users:

I’m very impulsive, that’s my huge thing. Like I could be fine now and two minutes later literally just see something and straight away I’m going to die...that’s my big problem like I just don’t think. ED19



This impulsivity is something that particularly needs to be considered when someone is left waiting long periods of time in the ED while unaccompanied:

You are constantly fighting. You are having almost an internal battle in your head. Should I stay and get help or should I act on my impulses. Because a lot of the time when I show up to A&E I'm in such a dark place and the only reason I was going to get help so it didn't impact on my family. ED04

## Chapter 8: Impact of Negative Experiences

### 8.1 Introduction

This chapter sets out the findings relating to how the negative experiences reported in the previous chapter impacted on participants in a variety of ways. Three main impacts were identified:

- Experiencing shame
- Being (re)-traumatised and increasing distress
- Wanting to leave

### 8.2 Experiencing Shame

Many participants were initially negative or ambivalent about seeking help in the Emergency Department for their self-harm/suicidal behaviour especially as it would entail bringing attention to themselves and their family:

So we drove there and we got there and we went in. I was so embarrassed I didn't want to go up because I was like nothing has happened. Obviously I had to go. ED09

At the time of arriving to the Emergency Department, many participants were also experiencing a strong feeling of shame. They largely described feelings of being ashamed of themselves following their incident of self-harm or suicidal behaviour. In some situations, participants were shocked that they had tried to kill themselves while for others having survived was unexpected and painful. Many participants also described feeling ashamed over having lost control by self-harm and consequently exposing their feelings of despair and vulnerability to others:

You know you feel bad anyway, you feel embarrassed, why did I do this, impulsive. ED10

Participants also commented on feeling a burden to their family and friends or of wanting to apologise for their behaviour:

And at that stage I had started, I was kind of with it a bit more and I was like beginning to feel regret for what I had done I felt sorry because my friend had met me in the Emergency Department and my other friend had come along. ED06

I was mortified of what I've done and the effect it has on my family. Never felt like the effect it had on me, because at that stage I wouldn't have been in that place. It felt like I was taking time up in A&E. ED10





Although each participant's experience of shame was personal and unique, participants who were ashamed about themselves typically commented on feeling extremely vulnerable, fearful and emotionally fragile. Consequently, participants reported that feeling ashamed about themselves and their behaviour often made it difficult to accept the need for help and more importantly, to occupy a space in a busy Emergency Department where their distress, self-harm and suicidal behaviour became public and was seen by others:

I felt that people were looking at me, wondering why I was there. I didn't look sick but I was crying. But at the same time in my head I was thinking that I shouldn't be there either you know. It made it hard to sit there. ED28

There are sicker people than me and I ended up being in A&E. You're sitting there on the chair and you see really sick people. You don't feel that you should be there, you're just taking up their time and their space. They're busy and they don't need you. Now I know that's probably about me. Because I'm feeling not good about myself, otherwise I wouldn't have done what I done. ED18

Almost all participants described that their initial encounter at the Emergency Department was emotionally difficult. Presentation to the Emergency Department entailed participants talking to different members of staff about personal information and difficulties and often without knowing the purpose of the conversations:

I am very protective over my story, I didn't want people to know that I was struggling as much as I was. I had, you know I would've been very high functioning. But I had this underlying kind of thing that only my GP knew about and my counsellor knew about and my very close friends knew how bad it was. So I was very defensive about everything. ED09

For some participants it was particularly difficult as it was their first time to disclose information about their self-harm, suicidal thoughts and behaviour to a health professional.

It was my first time in the Emergency Department; it was embarrassing telling someone what you did, only my family knew about my self-harm. ED19

Feeling vulnerable and a sense of shame, the participants were sensitive to the attitudes and behaviours of staff and feared being judged, misunderstood and exposed. Participants reported that various aspects of the care from staff in the Emergency Department had an influence on their feeling of shame. Most importantly was the participants' perception of how they were treated by the personnel. As described in the next chapter, many participants experienced some staff as kind, respectful and non-judgemental, which helped participants to feel less ashamed. Being treated with kindness and respect during their initial encounters at the Emergency Department alleviated their initial feelings of shame after their incident of self-harm and suicidal behaviour, and helped them make the decision to accept help:

Some nurses were very, very nice to you, you know you feel bad anyway, but that helped. ED10

In contrast, however, a large number of participants reported that their feeling of shame and distress were exacerbated when they felt that they had exposed themselves too much and when they experienced the staff in the Emergency Department as unsympathetic, disrespectful, authoritative and punishing:

I wasn't shamed. Because I'm already ashamed. But I don't need to be treated as if I should be ashamed. Do you know what I mean? ED10

I understand its very understaffed, it's ill organised. From a more personal level there's a feeling of no compassion, like you are just, the number of the kind of hospital band that they give you, you know the band that's always on your wrist. You feel very much just that patient number. And at a time when you need the most reassurance that you're ok and that you're still kind of in reality in your head, it's the worst possible kind of way to go about it. Again like for me I'm constantly conflicting between I understand where the individual doctor, registrar, nurse is coming from and like what they have to do but the service as a whole is disappointing. ED05

Many participants described great sensitivity to staff attitudes towards them and towards their self-harm or suicidal behaviour. Participants also commented on feeling exposed to others and experiencing negative attitudes from the Emergency Department personnel, all of which contributed to an exacerbation of shame for some participants:

It's the stigma against mental health, it's that there's something wrong with somebody for them to think like this. It's attitudes and beliefs that need to change. ED14

Some participants also reported that they did not feel that they were met with respect and interest in their individuality:

They just they didn't care. They didn't ask me anything other than 'why are you here? Why are you feeling this way?' And then when I told them it was like but you shouldn't. How can you tell me why I shouldn't feel the way I do? ED01

For some participants having their despair undermined or not taken seriously prompted them to feel more ashamed of having self-harmed or attempted suicide:

I just felt embarrassed that it was, I felt that even in my own head I felt it was such a big deal. But then it didn't seem to be made out to be such a big deal. So then I was like maybe it's not that big a deal. And then I just felt stupid for all the situation do you know. ED18

And it was just basically, yeah that I kind of had to cop on and move on and think of others and not thinking of myself. That I was selfish to have such ideas and such thoughts when I had 2 young daughters and a husband at home. And yeah, so she made me feel very bad. ED12

As described in Chapter 6, the environment of the Emergency Department entailed the participants being exposed to noise, crowds and people who were physically unwell. As well as dealing with unhelpful and negative responses from staff, participants reported their sense of shame being seen by other patients in the ED, and they feared how others might perceive their behaviour and need to attend the Emergency Department.



Because I just felt so alone and so guilty because I was taking the doctors and the nurses time because I could see people on trolleys. I still remember there was an old person that was left, their head was all covered in blood and she was in pain and I could see her waiting to see a doctor and I was waiting for a doctor for something, there was nothing physically wrong with me, I was taking somebody's time to see physically ill patients. I felt awfully guilty, awfully lonely. ED12

The participants' feelings of being exposed were described as inner experiences that occurred both during interactions with others and during times of aloneness.

### 8.3 Being (re-)traumatised and increasing distress

Several participants described that their experiences of attending the Emergency Department and the responses they encountered by personnel was extremely unhelpful and in some instances increased their distress. For a number of participants, presenting to the ED and being treated in a negative and uncaring manner confirmed their own negative beliefs about themselves:

I wasn't being taken seriously....and that kind of made it only worse. I was feeling like you see I was right I am useless, this is absolutely useless sitting here...it just kind of confirmed to me that life wasn't worth living to be honest. ED44

This participant describes being in a worse state after her presentation to the ED and this is something that was echoed by a number of other participants:

They thought that I purposely did this just for, I don't know, I just felt really, I felt bad before I went but coming out I felt even worse. ED27

The whole experience for me was just horrible. I felt worse if that even was possible. To go in there the way I was and to actually feel worse. I felt like I didn't matter and I was just a nuisance. ED03

I'd say it's more traumatising that what had actually occurred beforehand. Just added to the trauma. It was the worst thing that could have happened. ED02

For some participants, the impact of the increased distress from their experience of attending the Emergency Department was both short and long term. For some, it made them determined to not attend the Emergency Department for their self-harm or suicidal behaviour again.

### 8.4 Wanting to leave

Many of the participants described a readiness to leave the Emergency Department if staff showed any scepticism or uncertainty regarding their need for help. Some left the Emergency Department before assessment, while others were prevented or encouraged to remain by staff or their family member:

I was a problem. And I remember bolting and she had, she got security to pin me down outside and I remember my whole dignity was just gone at that stage. She had like five or six security holding me down and I was just trying to tell her if I'm that big of a nuisance just let me go home I'm fine now, I'm okay. ED12

And she asked me to come back to waiting area and I was waiting about six, or seven hours. So I have to wait the next couple of hours to see the doctor. And I just gave up and I went home. And I was walking around the streets for the next couple of hours. ED38

Several also reported that waiting for long periods with their thoughts of shame triggered their desire to leave in order to the cope with their frustration and distress:

I suppose you're embarrassed that you didn't even think you'd end up there and then the reality of, God now I'm here. And all these people are looking at me and wondering what the hell I'm here for. And the staff are a bit cheesed off that I'm in their way. ED14

Again it's the whole kind of alienation thing. You're sat in that chair and like I just felt like I was taking up space. So I kind of went up and I said, look I'm actually feeling better now can go home. And she was like no you can't like. ED02

In addition to making participants want to leave the ED, the negative experiences they encountered also impacted on their intention to seek help in the future from the ED with many reporting that they were never return again:

Like I would never go again. And I am not sure what I would do or where I would go to but never there again. There's just no point like. It doesn't help and you are in the way. Never. ED23

The negative experiences also left participants feeling very disillusioned about the help available for them:

You get told your whole life that if you're in that state you are supposed to reach out for help. And then when you do, no one helps you and you feel unsafe in the world. And you feel there's no point you know. Because you went and you took that step and no one was there to catch you or look after you. ED16.

## Chapter 9: Positive Experiences in the Emergency Department

### 9.1 Introduction

There were many participants who reported positive experiences when they attended the ED. Positive experiences relating to assessment, treatment and discharge have been identified in Chapter 5, particularly relating to when participants were assessed by specialist mental health staff. Positive experiences relating to the ED environment are presented in Chapter 6. Most of the remainder of positive experiences related to the interactions that participants had with staff at the ED or other people they met on their journey either to or following their presentation. In addition, there were some references to positive experiences of aftercare.

### 9.2 Interpersonal Skills

Interpersonal skills speak to the ability to communicate well and relate to other people. The most common positive experience expressed by the participants was the positive interactions they had with the staff in the ED. Counter to the narrative that many of the staff were cold and uncaring, there were many staff who were warm, friendly and caring. Throughout the responses there were references to interactions that were positive and these impacted on the participants and made their time at the ED more bearable. The positive interactions were also perceived as helpful, reassuring and supportive and were a strong indicator of whether the participants had an overall positive experience with the care that they received. In many of the interactions that the participants described, the skills described were not complex psychotherapeutic interactions, but were everyday communication skills that demonstrated warmth, compassion and a caring attitude. In these instances, the participants talked about the staff member being 'nice' or 'kind' and 'lovely'. One participant described this as the 'personable-ness' of the staff and their ability to be human and to treat others as human beings. Other staff who engaged with the participants when carrying out assessments or attending to wound care were also described as 'caring', 'compassionate' and 'empathic'. In addition the provision of time was very important in terms of the participants perceptions of their experience and when it was provided, the participants placed a high value on it. Time was particularly appreciated as many of the participants understood how much pressure the staff in the ED were under. The provision of time allowed the participants to make a connection with the staff member and to talk about their experiences and to be heard. These experiences are highlighted in the following quotations:

The last time I was in I got a superb registrar, superb. And he was very encouraging... he told me about stuff and I made up my mind about going to the public system. He didn't have a book in front of him. He sat with me. Like this. He treated me like a human being that had problems and that needed help. He was just lovely. He just, it felt like he cared, he actually cared about what I happened to do next...He listened to what happened to me. ED10

And I arrived there, it was around 1 o'clock in the afternoon and I was seen pretty quickly by the nurse in triage which was lovely, she was a really lovely woman. So I felt really bad because she was really reassuring me and saying you're perfectly fine, don't worry, we're going to take care of you. ED12



But with me she was very kind of calm, understanding, let me express things and would ask if she needed. Yeah it was reassuring because it didn't feel like I was just being thrown out, you know. ED31

When staff demonstrated these skills, or even when they tried to interact with the participants, they were perceived as being non-judgemental and the participants felt that they were being treated as a human, with dignity and respect and that their concerns and experiences were being taken seriously. In addition, it provided reassurance to the participants that they had made the right decision to go to the ED to seek help and support. In the following quotation, the participant talks about how the triage nurse put her at ease and told her that she was in the right place:

She [triage nurse] was just, she hugged me like because I was saying to her I shouldn't be here, I shouldn't be here and she was like yes you have to and we'll take care of you and she was just so warm and caring and I really felt a genuine connection even though it was just for 20 minutes, the time that she took my temperature and everything. But she was talking to me and she was like kind of, not telling me that everything was ok but like that I was in the right place, that that's where I should have been at that time. Which was very reassuring at that time. ED12

The provision of information was also perceived as important and staff explaining to the participants what was going to happen and explaining procedures was perceived as helpful:

And I was like so I'll have to do all this again and she was like well not in depth but you know she will assess you again, so it would be a long conversation you would have with her but not so many tick boxes like you know. And I was like ok. And she was able to kind of help me navigate what kind of would happen next which I think was really helpful. ED32

There was one example of a nurse who really went out of her way to support a participant. In this example, the nurse in question spent additional time with the participant when she didn't have to, which really demonstrated that she not only cared but that she would provide support and assistance to the participant. This made a real difference to the participant and was perceived as extremely helpful at that time and the nurse was described as 'amazing':

I think I had one good [experience], to the point where a nurse actually came in, on her break to talk to me. Like she went completely out of her way to talk to me like. And she was just talking like. It started off general and then I started to cry and then she started to get a bit emotional and I was like, oh my god she cares. And she was like 'my daughter's been through bad experiences, so I know what it's like. So I'm not going to spend my lunchtime in the cafeteria I'm going to talk'. And like I just like can't cope, like I feel really bad. And she was actually like sound, like she was like 'oh that's okay, like I'll get you help. And we'll work together' and whatever. Like if someone says to me we'll work together I would try. That makes such a difference instead of, we don't have time. ED19

Along with the warmth, compassion and care, there were some actions that accompanied those interactions. For some of the participants it was the manner in which the staff member carried themselves when they were carrying out routine or specialised assessments and for others it was small but important actions that cemented the verbal communication strategies used during positive interactions. In one example the participant describes the registrar who carried out the assessments emphasising how she carried them out rather than the assessment itself:

I have met a fabulous registrar there as well. Now it's a good number of years ago and she was, and she was a student but she was amazing. She was just connected, she was lovely. They don't have a table, she sat down and talked to me about how I was and what I was doing and she seemed like she genuinely cared. ED10

Another participant talked about how the nurses who were looking after her were caring and thoughtful offering her a blanket to wrap around her and in another example the nurse got the participant a cup of tea. A mental health nurse arranged and paid for the taxi to take a participant home following their presentation as they had no means to do it themselves and this was met with gratitude. Involving the participants friends and family was also seen as important and was valued by the participants. In another example, the participant describes how the nurses checked in on her a number of times which provided a sense of security and safety. These actions demonstrate the therapeutic potential of these interventions that could be overlooked in an environment such as the ED especially for people experiencing mental distress. Some of these points are highlighted in the following quotations:

Actually what they did was, they checked in with me a number of times, so I thought they were on the ball in as much as they could be. ED06

Yea like even the ones who would've been very nice and you know one of them, the younger ones got me a cup of tea and you know they tried. So that was lovely and they tried, you know a lot of them tried. ED14

Like you know the nurses that were you know taking your blood pressure and that kind of stuff, they were more caring, they were more, you know like you know the paper suit, they were like here's a blanket to wrap around you because it's see through like and they were the ones who were like making sure that I was ok-ish and stuff. ED31

There was recognition the ED was not just about nurses and doctors and there were some references to the entire team being lovely. This included the receptionists, cleaners and porters. While most of the interactions the participants had were with either doctors or nurses, there were some references to other health care personnel or other professions who became involved such as the ambulance drivers and paramedics, the coastguards, and the Gardaí who either took the participant to the ED or were involved in their onward journey. One participant mentioned her General Practitioner who referred her to the ED and how instrumental they were in the overall provision of care. Another participant talked about the taxi driver who took her to hospital and how he helped her stay calm on her journey to hospital:



And I just said ‘I tried to kill myself I'm really depressed and I want to die’. And he just went ‘okay’...but he kept me like calm the whole time. The whole time he was the most lovely man, he was like ‘you can smoke in my car if you want’. He was like ‘I know you are not meant to smoke in taxis but I can see you have cigarettes if you are stressed smoke please, talk to me’. And I did, (laugh). ED01

### 9.3 Aftercare and Follow Up

A few of the participants talked about the aftercare and follow up they received following their time in the ED. In one example, the participant recalled how prompt the aftercare was and described how the mental health services contacted her pretty much the next day to schedule an appointment. In another example, the participant remembers how the hospital called her every week for a few weeks to check in on her to make sure that she was doing OK and if she needed anything. This follow up was perceived as helpful and reassuring and was described as ‘great’ and ‘amazing’. In another example, the participant talked about the continuity of care that she received between the ED and the mental health services that she attended following her presentation. As with the other participants who talked about aftercare, she described receiving an appointment within a week and being very satisfied with the services provided. This included visits from a mental health nurse who was also described as amazing:

I think it was about 4 days or something I had an appointment. And I went and spoke to [name] who actually knew who I was from somebody else who had attended there. So I didn’t have to go into a lot of detail about any of that thank god. But when I explained everything that was going on at the minute she was like ‘ah it’s no wonder you’re feeling very overwhelmed’ and whatever else. And she was like ‘ok so this is kind of what we can offer you’, so I got a psych nurse that started visiting me twice a week. That was amazing, I have to say if it wasn’t for that I don’t actually know what would have happened to me, she was the one who really pulled me out of the rut that I was in or rather helped me pull myself out of the rut that I was in. Her support and encouragement was amazing. ED32

In addition to the emotional support and access to interventions that were provided by the mental health services, another advantage was that the participants had a point of contact in case they needed additional support. This meant that they could avoid attending the ED if a crisis was emerging:

And they signed me off then and back to him you know yet they told me when I was finished in [names mental health service] that I was part of their team. And they said that you know if I feel bad again that my first port of call is the doctor. But they have me registered, you seem to be always registered with them. Like he can refer me straight back to them rather than going back to the A&E. Obviously if I was going to do something you could be brought to the A&E, but like I think it’s amazing. ED48



## Chapter 10: Improving Service Users' Experiences in the Emergency Department

### 10.1 Introduction

While many of the positive experiences described in Chapter 9 could be translated into improvements, the participants provided specific examples of how they believed experiences can be made more positive. These improvements are discussed in terms of the availability of specialist staff, environmental improvements, education and training, not being left alone and aftercare and follow up.

### 10.2 Availability of Specialist Mental Health Staff

The most commonly cited improvement discussed by the participants was the availability of specialist mental health staff in the ED. Many of the participants who talked about this, talked specifically about nursing staff, either a mental health nurse, or a specialist 'crisis', 'self-harm' or 'SCAN' nurse who participants believed would be trained to deal with the emotional needs of someone who is presenting with suicidal behaviour:

I think they need a Scan nurse on site, because that was really beneficial to me when I was in the doctors. ED01

A nurse, or anyone with any kind of mental health, just to be there all the time. ED19

While for some, the discipline was unimportant, their skills, knowledge and expertise were, especially given that people who attend the ED with a mental health difficulty are often in crisis. It was a strong perception throughout the interviews that staff who had a mental health background were more likely to understand participants' experiences and to respond more sensitively to their needs:

For me speaking to a professional who deals specifically with mental health as soon as you get there is really important. No, for me it [the discipline] wouldn't matter. It would be just someone who is used to dealing with people in crisis. That could be a nurse, a social worker, could be a psychiatrist it just makes a huge difference to the whole experience if you've got someone who understands what you are going through and that would make a huge difference. ED04

There should be somebody on every A&E shift that can cope with, or can at least give that person five minutes and be trained to understand mental health issues are just the same as any other issues in the [ED]. And that like in a way the lady in the room that was on the machine she could well have died, but I could well have died as well you know. ED 14

While the availability of mental health professionals was considered important, there was also discussion about the need for them to be available around the clock with some participants suggesting that there needed to be at least one person who had mental health training and experience available at all times, while



others believed that there should be an entire mental health team who could respond to mental distress. This suggestion was not just in response to the prevalence of self-harm and suicidal behaviour, but also a reference to the high numbers of people experiencing other forms of mental distress.

### 10.3 Environmental Improvements

Throughout the interviews there were references to the unsuitability of the ED as a therapeutic environment for people who are experiencing mental distress especially self-harm and suicidal behaviour. Participants who had positive experiences often talked about a dedicated area or room where they were able to discuss their issues of concern in a quiet, calm and private environment and there were many who believed that the availability of a private room would enhance their overall experience. This was partly to do with confidentiality, and participants talked about not wanting to talk about their mental distress when people in other cubicles could overhear them:

I think yeah, I think, again I suppose it's ideal but I think if there was one person, one mental health nurse on duty in an A&E and it was their job and they had a room that they could, you know, assess people in or, because even, you know, being brought into a cubicle with curtains and you know that the person beside you, because you've heard everything that's said to the person beside you. ED33

While a dedicated private space was perceived as important, some of the participants went further and called for the establishment of an emergency mental health department than would run alongside the traditional ED but would care for people who were experiencing a mental health crisis such as feeling suicidal. These departments would have specialist mental health staff who were also able to manage some of the physical problems that might present in tandem to mental health difficulties such as self-poisoning or suturing and wound care. One participant summed up why this is necessary by stating that people experiencing distress are told to go or sent to the ED when experiencing a mental health crisis, however, the ED is not equipped or set up to manage this. The ED's primary function is to manage emergency physical health presentations and this influences the overall structure and process of the department furthering the need for a dedicated and specialist service:

For me I think to report to the Emergency Department when its mental health related, I just see someone sitting there with a broken leg or something, is not the best scenario. I think if it was possible there should be separate places where you can attend to. So if you're going to an Emergency Department, you're not just going to be put on a trolley in the hallway or put in a bed or somewhere, where people around you have more physical ailments. It should be like ok you're going to be assessed in the sense that there's a space where its safe, its calming as well. And that you can get the attention you need without just a doctor saying why did you do this. ED05

Well like I mean I don't know if it's even possible in Ireland. But ideally, an emergency room, department, whatever. Set up especially for mental health issues. But is also equipped to deal with poisoning, to deal with cuts, to deal with you know maybe whatever it is that the harm has come from. And then the other side of it is that they're just, they're able to talk to a person. That they've been trained properly to talk and I suppose to really pull apart what's going on here. And how can we help, how can we help you want to live. How can we help you when you leave here that you know you're going to be safe at least for another few days, until we can meet you again and support you. ED09

There was a sense in some of the responses that the ED contributed to the shame and the embarrassment that participants felt and an environment that was specific to people who had mental health difficulties would lessen this tension. In addition, there was a perception that some of the participants believed that they were not considered 'sick' because they were not physically sick, and this was partly the reason that negative reactions existed. A specialised unit where everyone was experiencing mental distress would reduce the likelihood of this happening. Furthermore, one participant suggested that she would feel less alone if she knew that everyone else was experiencing mental distress as well:

If you're in a waiting room, like it's going to be awkward enough as it is. But you wouldn't feel as alone if you're looking around and being like you know all these other people are feeling what I'm feeling too, you know. ED11

In addition, in a dedicated department with trained staff, it was believed that it would naturally be more responsive and caring and this might reduce the number of people who wanted to leave. The strong emphasis on physical health within the ED also contributed to the type of interventions that the participants received which focused on activities such as managing wounds or dealing with self-poisoning with a lack of attention to the participants' emotional needs. Given the perceived dichotomy between physical and mental health, it was believed that a dedicated service for people experiencing mental distress would provide a more integrated approach with a stronger emphasis on psychosocial needs rather than a purely medical and physical health dominated system. There was also the perception that help-seeking would improve if there was a viable alternative to the ED:

Going through A&E is always the last resort for me. By the time I end up there I'm usually in a state. But I feel that because of the lack of support in the evenings or weekends or whatever I would say a lot of people would seek help quicker if they didn't have to go through A&E. ED04

## 10.4 Education and Training

There were many references to the need for education and training for staff who didn't have a mental health background who worked in the ED. There was recognition that general medical staff and general nurses were perhaps not trained to work with people who experienced mental health difficulties and this needed to be addressed. Emphasis needs to be placed on helping the staff in the ED to understand the experience of people who are suicidal and to equip them with interpersonal skills to respond more sensitively. Many of the participants talked about staff needing to be more caring generally and others were more specific about the type of interpersonal skills required. Some talked about the need for compassion and this seemed to



encompass a range of interventions that communicated to the participant that they were valued, that they were being listened to, they were safe and that they were going to be supported. In addition, negative attitudes encountered by participants were perceived as the result of poor understanding of self-harm and suicide that might be improved through education and training. Furthermore, education and training might help the staff be more empathic towards people who are suicidal and respond in a way that was more compassionate. In the following quotation, the participant talks about the importance of being listened to in the ED:

I'd just say, the best advice I could possibly give is actually listen to the person that's sitting in front of you. They're not just a number, they're not just there for the sake of being there. They're there asking for help, we're crying out for help and we need help. And just and especially when someone tells you they have a plan. Like if someone tells you they have a plan and describe the plan down to the detail of what they're going to do. That surely that has to be alarm bells. ED15

While specific mental health training was perceived as important overall, many of the suggested interventions that could improve the overall experience for participants were not psychotherapeutic interventions, but they did have potential for a therapeutic effect on the participants. For example, participants felt cared for when staff told them that they were going to be looked after, asked them about how they were feeling, got them a warm drink, checked in on them periodically to see how they were or if they needed anything and provided information about what was going to happen to them. There was recognition that these approaches are not exclusive to mental health professionals and there was a lack of understanding about why they were not practiced. For example, in the next quotation, the participant recognises that nurses are busy and did not expect them to sit with them for hours. However, checking in on the person would have made a huge difference:

I think it would have been helpful for them to bring a nurse in maybe even for ten minutes talk to me before she [the psychiatrist] came in, I understand nurses are busy, I know it's busy and there's lack of staff and all that. So I don't expect someone to sit with me for six hours or five hours. But I think if a nurse had just come in even for ten minutes or for you to be checked on every so often. Not just left for hours. ED03

Similarly, in the following quotation, the participant talks about some of the things that would have made a big difference to her during her time at the ED

I just think that perhaps if they were brought into a room and they were given, I don't know things there to read or there was a radio on and you know they were given a cup of tea and told look it's going to be a few hours but just hold on because it's worth it and you know and every once in a while a nurse just threw their head in and just kind of went are you alright, ok don't worry, like you know. We're all thinking of you like kind of thing and just encouraged I suppose that you're doing the right thing by staying here. Because if I didn't have my brother in my ear like that, I wouldn't have stayed, so I definitely think encouragement a little bit like and I don't think that that would be a massive thing on their place to do for somebody so you know. ED32

There were many references to these small but important interventions that were perhaps overlooked or not perceived as important and education and training might help to improve the overall experience. In addition, there were a small number of participants who suggested that staff at the ED might not be able to find compassion because of the pressure they were under. If this was the case then staff needed to recognise this and seek support to resolve that issue:

Yea well I think for nurses if the nurses are getting to that stage where, because I mean as I say I work in [names County]. And like there's weeks I just can't hear anymore because someone is feeling suicidal because I've had my fill of it. If they get to that place they need to have, be able to put their hands up and say actually I'm at, I'm not able to find the compassion I need right now. And go and do something else for a while. ED34

### 10.5 Not being Left Alone

While this has been briefly addressed in the previous section, it is worth giving it a little more attention here. Some of the participants attended the ED alone and there was a sense that this was a challenge for them. Throughout the responses there was a sense that the participants were in a very vulnerable and fragile state of mind and sought refuge and security within the ED. However, following initial triage and assessment many of the participants found themselves alone, waiting for hours to be seen by the mental health team. This aloneness heightened the distress that the participants experienced and there were calls for this to be addressed. This distress is highlighted in the next quotation:

Well I feel really that I don't think somebody should be left on their own when they are so upset and distressed. I was left completely on my own for a long period of time, many, many hours and I think that it would improve if there was somebody there even keeping an eye on you. Oh it was extremely hard, extremely difficult. Your mind is kind of reeling and you feel like just you have to get out of there you've got to get out. ED27

In some cases, it was anticipated by the participants that they wouldn't be left alone as in the next quotation:

I was thinking when I, that was my idea in my head. When I would go there to hospital, first I'm going to see the doctor, like immediately. If not I will see either nurse or someone will just sit with me. Because I was in my own head. And nobody, like my friends and family members, they couldn't sit with me on those evenings. So I was feeling that I really need to be with somebody to talk to. To sit like close really to me to make you feel like be safe. And like physically safe. ED38

One of the participants talked about an innovative approach that is being run by the HSE where a trained volunteer sat with people who are experiencing distress which she felt was an effective way to manage the loneliness that they might be experiencing.



Yeah, I actually read about a really interesting initiative that the HSE are doing down in, I think its [location] at the minute where on a weekend if anybody turns up at A&E on a Friday or Saturday night or during the day on their own that they have a volunteer, someone who is trained up who can sit with them. And I really like the sound of that. Because it's such a lonely experience and even if you had somebody with you they often are just as scared as you are. So if you had someone who was trained up even just to sit with you for an hour until you got seen, that would really make, I feel that would really make a difference. ED04

## 10.6 Aftercare and Follow-up

Most participants believed that people who presented with self-harm or suicidal ideation should not be sent home without a specific plan for aftercare and follow up. For the participants who talked about this, they stressed that people who self-harm or experience suicidal ideation not only need to be seen by a mental health professional within the ED but they also need to be able to see a counsellor or therapist soon after they are discharged. This point is exemplified in the following quotation:

But I don't think you should be sent straight home. I think you should be brought straight to a proper counsellor and have a proper sit down and a talk. As long as you need to talk and then have a plan. For them to tell you a plan like as in, okay I'm going to see you now on this day, this day, this day. And it should start off, it should be once a week thing because that's just too spaced out for someone who's feeling, if you're feeling that bad. I think it would be brilliant if you weren't just sent home because you're going like. If you're feeling that way you're just going to go do it again. So you need to go and you need to talk to someone as soon as possible. ED11

When this didn't happen it was a source of distress for participants. In one example, the participant describes being sent home without any planned support and the impact that this had on her:

Because I would have needed to be kept in the hospital for a few weeks. And I was just sent home. I was just sent home with no support, I was literally going back into the situation that made me very stressed and very anxious and very, just oppressed and sad. And I would have needed that space and unfortunately, they just asked my husband to take me home, literally 12 hours after I tried to end my life. ED12

Where referral and aftercare were in place for participants, it was perceived positively, further supporting the need for standardisation across Emergency Departments.

## Chapter 11: Brief Discussion and Conclusion

### 11.1 Introduction

This study provides an in-depth exploration of peoples' experiences presenting to the Emergency Department with self-harm or suicidal ideation. Findings suggest that there is a great deal of variability in the care provided to people following their presentation. While some participants reported having very positive experiences in the ED, unfortunately many others had negative or mixed experiences. For people who had negative experiences they were rarely as a result of one single factor and rather reflected an interplay of issues including interpersonal factors, environmental factors and factors concerning service provision, some of which will be discussed briefly here.

### 11.2 Brief Discussion

One of the main questions arising from the findings of this study is the appropriateness of the Emergency Department as an environment in caring for people who present with suicidal ideation. Almost half of participants in this study presented only with suicidal ideation and did not have physical health needs. Some were referred by GPs, sometimes as a means to get quicker access to mental health services and some self-referred in the most part in response to the public discourse that the ED is the place to present to when in crisis. However, there is an argument that the ED is an inappropriate environment for someone presenting without physical health needs who could be better assessed by mental health teams in the community. As previously discussed, the very busy and often chaotic environment of the ED means that people will have long waiting periods to be seen, particularly if they are presenting with no physical injury. As these findings have identified, waiting in a busy and noisy ED environment can often add to the distress a person is experiencing. There have been calls from many organisations and services for the provision of crisis mental health services both within-hours and out-of-hours. This is supported by studies which demonstrate that the provision of 24 hour crisis care is associated with a fall in suicide rates (While et al. 2012).

Crisis houses were identified in A Vision for Change (AVFC) (DoHC, 2006) as one of the physical resources required to support the work of Community Mental Health teams and AVFC recommended that each catchment area have access to a crisis house. In addition, AVFC recommended that each Community Mental Health Team have a 24/7 crisis intervention response with the capacity to respond in a multidisciplinary way to each individual's crisis. However, 14 years after publication of this policy framework for mental health service provision, little progress has been made on the provision of crisis 24/7 out-of-hours mental health services which means that the ED remains the first port of call for most people.

Findings from a recent report of a consultation with mental health service users in Ireland by Mental Health Reform found that only one in five participants had someone in the Community Mental Health Services that they could call on out-of-hours in a crisis (O'Feich et al. 2019). Just under one-third of participants reported having attended an ED to seek support for a mental health problem with half of these stating they did not receive the support they required. Qualitative responses identified that a need for 24/7 crisis orientated services and reduced reliance on the ED for out-of-hours care was reported frequently by mental health service users. On the basis of this report, Mental Health Reform have recommended that a 24/7 response be made available to existing service users experiencing a crisis and that service users and their family members know what to do when in crisis.



Another recent report by the Mental Health Commission on the provision of acute mental health beds in Ireland has also recommended action be taken to improve access to and availability of acute mental health beds (Malone & Wrigley, 2020). Included in the recommendations of this report are the maintenance and restoration of local acute mental health beds in addition to a review of existing 24-hour community mental health service provision. This report highlights an almost complete absence of crisis houses (as recommended in A Vision for Change) in addition to other mental health services throughout Ireland.

A Vision for Change (DoHC, 2006) identifies the GP as the main access point to specialist mental health services for most of the population. This was true for many participants in this study who presented to their GP in the first instance with their mental health difficulties. However, it was clear from participants' accounts that GPs referred people to the ED sometimes as a last resort to try to get them access to mental health services. This illuminates the difficulties that GPs have in referring to mental health services and in particular the lack of out-of-hour crisis mental health services. It also supports findings from other studies internationally which demonstrate the lack of services and interventions available to GPs to refer people to when they present with self-harm or suicidal ideation (Mughal et al. 2020; Saini et al. 2016).

In the absence of sufficient and appropriate crisis mental health supports in the community, the importance of the Emergency Department as a care/treatment setting for those presenting with self-harm and suicidal behaviour is clear. As identified in Chapter 1, the establishment of a National Clinical Programme for the Assessment and Management of Patients Presenting to Emergency Departments following Self-Harm (HSE, 2016) in Ireland speaks to the priority afforded to this particular area of service provision in mental health. When considering the findings of this study, it is important to note that the NCP has only been in operation since 2014 starting with 16 EDs (HSE, 2017) and expanding to 24 of the 26 adult EDs at the time of writing. Participants in this study were reporting their experiences of presenting to the ED going back to the previous 5 years and as data recruitment took place over 18 months it is likely that some experiences reported in this study pre-date the roll-out and expansion of the NCP. It is notable that when most participants were liaising with healthcare staff from the NCP the experiences and outcomes were generally better. However, there was significant variability in the availability of staff from this programme for participants who presented and there was a large degree of uncertainty among participants about what mental health staff they actually saw.

The vision of the National Care Programme (NCP) states that "Every individual who presents to the Emergency Department following an act of self-harm or with suicidal ideation will receive a timely, expert assessment of their needs and be connected to appropriate next care. The individuals and their family are valued and supported by staff who themselves are valued and supported" (HSE, 2017: 1). In 2018, 72% of patients who presented to the ED with self-harm received an assessment from a mental health professional (Griffin et al. 2019). As identified in Chapter 5 however, there was significant variability in the quality of the assessment provided to participants in this study following their presentation to the ED.

A number of participants reported their assessment as being a mechanical, tick-box and reductionist process. The NCP identifies the need to undertake a biopsychosocial assessment which can incorporate the use of risk assessment tools but cautions against their use as a substitute for a comprehensive assessment (HSE, 2016). The tick-box approach of many risk assessment tools has the potential to negatively impact on clinical decision making by limiting the amount and quality of information collected by healthcare staff (Higgins et al. 2016a). In addition, studies have shown that the use of predictive suicide/self-harm risk



assessment tools in the Emergency Department have limited utility (Mullinax et al. 2018; Lindh et al. 2019). Participants in this study understood the need for questions to be asked within an assessment following their presentation to the ED, but identified that the way these questions were asked was very important. The deeply personal nature of the mental distress which led to self-harm or suicidal ideation did not lend itself to a quick question and answer process, however, when questions were asked by someone in a caring, engaged and unhurried manner this contributed significantly to a person's perception of their care and treatment being positive. While a standardised approach to the assessment of self-harm and suicidal behaviour is advocated by the NCP, caution is required to ensure that the process is not overly standardised allowing little room for personal narratives and perspectives which may feel too procedural to patients (MacDonald et al. 2020). In addition, it is imperative that assessments for people presenting to the ED with self-harm or suicidal ideation should focus not only on risk but also on safety planning including current and future supports available to the person (Higgins et al. 2016b; MacDonald et al. 2020).

Another key issue identified in this study was the sometimes negative and unhelpful attitudes that participants experienced from staff they engaged with in the ED. This finding supports those of many previous studies both nationally and internationally as reported in Chapters 1 and 2. However, the experience of negative attitudes was particularly prominent in those who had engaged in repeated self-harm (n=29) and had presented a number of times to the ED. It is important to note that reducing the rate of repeated self-harm is one of the key objectives of the NCP as repeated self-harm is a significant predictor of completed suicide (Zahl & Hawton, 2004). Working with people who engage in repeated self-harm can pose a particular challenge for healthcare professionals, however, an increase in knowledge and understanding of self-harm can result in more recovery-orientated practices when working with this client group (Murphy, Keogh & Doyle, 2019). When an individual's personal meaning of self-harm is sought and understood by the healthcare professional it can help to facilitate recovery by contributing to a collaborative and relational approach to care (Morrissey, Doyle & Higgins 2018). Within this approach, the provision of an open, safe and supportive space in which the person can seek help without fear of negative reactions or judgements is central (Morrissey, Doyle & Higgins 2018). In the ED environment, the assessment of the person and the way it is undertaken has the potential to either challenge or confirm negative self-evaluations (Hunter et al. 2013).

This clearly identifies the need for all staff to have compassionate, empathetic responses including when interacting even briefly with people presenting with self-harm and suicidal ideation. However, in order to foster these responses, there needs to be a better understanding of self-harm and suicidal behaviour which can be achieved through education of ED staff. A recent small study of ED healthcare professionals in relation to self-harm in the ED setting in Ireland showed that ED staff also identify the need for further training the area of mental health generally and self-harm and suicidal behaviour specifically (Arensman et al. 2019). The Clinical Nurse Specialists working as part of the NCP have a defined role in the education of ED staff and in the cascading of skills in order to improve the triage and management of people who present to the ED (HSE 2016; HSE, 2018a). In order to operationalise this, CNS self-harm nurses undertake a 'train the trainers' course on self-harm and suicide awareness and skills in order to deliver a short 2-3 hour training session to all relevant ED staff (HSE, 2018a). However, it is reported that ED staff find it difficult to allocate these hours for training consequently CNSs are utilising clinical contacts as an opportunity to educate ED staff (HSE, 2017).

One of the performance indicators of the NCP is to reduce the number of people leaving before receiving an assessment and this can be achieved in some part by improving the environment and reducing the waiting time (HSE, 2017). Chapter 6 of this report highlights how there was significant variability across EDs in the provision of an appropriate room for assessment for someone presenting with self-harm or suicidal ideation.



While some participants were provided with a dedicated space to be assessed, many were not which impacted on their privacy and contributed to reluctance to disclose deeply personal and sensitive information crucial to their assessment and further treatment. Some participants reported that they were placed in an 'observation area' which was located centrally in the ED which facilitated observation from staff while the person was waiting for a mental health assessment, however, it also meant that they could be observed by others in the ED, which heightened feelings of shame and stigma.

One of the recommendations of the NCP is the provision of an appropriate environment for assessment which allows for observation to maintain safety but also protects privacy. However, these findings suggest that there is still a way to go until this is reached. At the time of writing and for many years preceding, EDs in Ireland are experiencing significant demand with overcrowding an everyday occurrence, therefore, space is at a premium in these departments. A recent review of the NCP highlighted that while dedicated rooms were available in many EDs to assess patients presenting with self-harm and suicidal ideation some were used for patients with physical problems who required isolation (HSE, 2017) and, therefore, were not always available for patients with mental health needs. Long waiting times are problematic but are a feature of ED care in Ireland. For patients presenting with self-harm and suicidal ideation long waiting times, particularly out-of-hours, are periods of high risk for patients to leave (HSE, 2017).

Another variable which appears to impact on whether people leave before receiving an assessment is whether they are accompanied by someone during their time in the ED. This study identified that one-third of participants presented to the ED unaccompanied by family members or friends and most found the long waiting time on their own increased their distress and their desire to leave without assessment which some participants did. Other participants reported that had they not had a family member with them encouraging them to stay, they would have left. A small number of participants reported being aware of a volunteer service which offers the person the opportunity to have someone sit with them during the waiting period in the ED and this initiative was viewed positively by participants. Participants appear to be referring to an 'Emergency Department Support Volunteers Initiative' which was operating briefly in St Luke's hospital, Kilkenny. This initiative was launched in March 2017 and was available to every person attending the ED for a mental health assessment on Saturdays between 8am and 8pm (HSE, 2018b). The trained volunteers were contacted by the triage nurse when their services were required. The service has since ceased as it was not utilised with sufficient frequency in this location. However, its potential for use in EDs with a high number of presentations and over an extended period of time requires further consideration.

Owens et al (2016) recommend that for those who present to the ED following self-harm, the provision of a 'sanctuary' within the ED where people could receive support from volunteers or peers while waiting for assessment and treatment could lead to better outcomes for patients and less demands on ED staff. In a more general sense, befriending as a service has been used by many mental health organisations/services to support people with mental health problems. It was first formalised by the founder of the Samaritans who defined befriending as the provision of companionship and support in a lay capacity to a person in need (Varah, 1980) and is operationalised by volunteers in many organisations in Ireland and worldwide. A review of the evidence as to the effectiveness of befriending interventions for mental and physical health problems demonstrates a moderate increase in positive patient outcomes and suggests that it offers potential as a useful complement to current clinical practice considering its high degree of user acceptability (Siette, Cassidy & Priebe, 2017). However, we were unable to find any literature specifically focusing on the

use of a befriending or volunteering service to support people who present to the ED with self-harm or suicidal ideation and this is an area that requires further exploration.

Another important issue to consider from this study was the significant variability in follow-on care once participants were discharged from the ED. As identified in Chapter 5, most participants were discharged from the ED with 11 being admitted to the hospital. Of those who were discharged, most felt they and their family members were not sufficiently supported in terms of referral to other services or provision of information which in some cases compounded a feeling of not being worthy of care. A review of the NCP highlighted that in 2016, only 47% of patients presenting to the ED received a follow-up call the following day (HSE, 2017) demonstrating an area for further improvement. In addition, it is recommended in the NCP that all patients should be provided with a copy of an Emergency Care Plan (ECP) which details information on suicide prevention and appropriate steps for next care. In this study, most participants did not receive a copy of this care plan and it is unclear if this plan was developed for them in the first instance. However, there were also some good examples of follow-up following discharge. Some participants received a follow-up call from a nurse the day after they were discharged from the ED. Generally, this was very well received, reiterating to participants that they were not forgotten about and that they were important. Contact follow-up following presentation at the ED for self-harm or suicidal ideation has been shown to have beneficial effects in terms of a reduction in further suicidal behaviour and an increase in the use of community supports (Stanley et al. 2018; Miller et al. 2017; Inagaki et al. 2015).

### 11.3 Limitations

The results of this study need to be interpreted in light of the following limitations:

- As this was a volunteer sample, there is a potential for response bias where those who have had a very negative or very positive experience are more likely to come forward.
- While efforts were made to include people presenting from EDs nationally, there was an over-representation of EDs in Dublin.
- There was an over-representation of female participants in the study (39 v 11).

## 11.4 Conclusion

The Emergency Department remains a key setting for intervention for people who present with self-harm and suicidal behaviour. How people experience the ED as a treatment setting can have a significant impact on their decision to disclose what they are experiencing and on their future help-seeking. Clinical management of people who present with self-harm to the ED has been recognised as a priority and is improving with the operationalisation of the National Clinical Programme (NCP). However, this study identifies that service users continue to experience considerable variability in the treatment and care provided across EDs in Ireland with many negative experiences reported by service users, particularly by those who present to EDs where the NCP is not in place or at a time when staff from the programme are not available. Negative experiences were largely focused on unhelpful interactions from staff, feeling unsafe in busy and noisy EDs, poor follow-up care and a lack of understanding around self-harm and suicidal behaviour. However, the many positive experiences reported particularly around empathic and relational approaches to care provide some examples of how care can be delivered compassionately to people in distress who present to the Emergency Department. Capturing these service user perspectives is important, and progress is required to work to translate these experiences, both positive and negative, into the direct improvement of care and treatment provided to people presenting to the Emergency Department with self-harm and suicidal behaviour.

### **Addendum Following Completion of the Study.**

Two significant developments occurred following completion of the study, and write-up of the final report that we draw readers' attention to here. Firstly, the Covid-19 pandemic resulted in a change in how service users utilised the Emergency Department for all presentations including self-harm and suicidal ideation. A significant decrease in attendance at the ED was noted at the height of the pandemic. HSE Clinical Guidance and Evidence on 'Managing Self-harm and Suicidal Ideation during the Coronavirus outbreak' (April, 2020) recommended that those experiencing self-harm and suicidal ideation be encouraged in the first instance to contact their GP or Mental Health Service before presentation to the ED. Alternative methods of care provision (e.g. phone, text, email, video link consultation), which may help support the individual, were also recommended. Where attendance at the ED was required, there was a recommendation for early assessment by the mental health team so that the person may move quickly through the ED. The longer term impact of Covid-19 on self-harm and suicidal ideation presentations to the ED will become clearer in time.

The second development was the publication in June 2020 of the refreshed mental health policy 'Sharing the Vision: A Mental Health Policy for Everyone', (Department of Health, 2020). A number of points made in this report are relevant to the findings of this study. In relation to General Practice, there is acknowledgement of the ongoing insufficient access to mental health supports and the need to scale up access to these supports for people presenting with mental health problems in the primary care setting. With reference specifically to the Emergency Department, there is recognition that the ED is a challenging environment for those presenting in mental distress. In an effort to prioritise non-ED based out-of-hours alternatives, Sharing the Vision proposes the establishment of out-of-hours crisis cafés to support those in immediate crisis to plan safely. The cafés will include access to talk therapies in addition to peer support provided by paid staff and volunteers. At this time, it is not clear how this will be operationalised and when these crisis cafés are due to commence.



**‘All I want is to be treated  
with compassion, to be  
seen as a person,  
something more than just  
my injuries because they  
represent what is going on  
inside my mind’.**

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